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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 precedental value.

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CITE AS

46 Van Natta ____ (1994)

In the Matter of the Compensation of
ROSA V. WATSON, Claimant
WCB Case No. 93-04131
ORDER ON REVIEW
Robert E. Martin, Claimant Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Referee Podnar's order that affirmed an Order on Reconsideration awarding claimant 39 percent (58.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. On review, the issue is extent of scheduled permanent disability.

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

Claimant developed bilateral carpal tunnel syndrome in July 1991, and underwent carpal tunnel releases in early 1992. On July 6, 1992, Dr. Wilson, claimant's attending physician, saw claimant for a follow-up post-operative examination. Wilson opined that claimant was stationary with no significant impairment, but recommended that she return if her continuing symptoms had not resolved by fall. Dr. Wilson never performed a closing examination. The claim was closed by a July 29, 1992 Notice of Closure that awarded no permanent disability. Claimant requested reconsideration. Medical arbiter Gritzka examined claimant and issued a report on February 9, 1993. Thereafter, an Order on Reconsideration issued on March 8, 1993, awarding claimant 39 percent scheduled permanent disability of the right forearm, based solely on Dr. Gritzka's report.

After the Notice of Closure issued, claimant was examined by Dr. Brown on December 22, 1992 and by Dr. Button on April 23, 1993, and reexamined by Dr. Wilson on three occasions between August 1992 and January 1993. The Referee admitted all the "post-closure" medical reports. However, finding that neither Dr. Brown nor Dr. Button was an attending physician, the Referee declined to consider their reports in rating claimant's impairment. Moreover, citing ORS 656.268(5), the Referee declined to consider Dr. Wilson's reports as they did not relate to claimant's condition "at claim closure."

On review, the employer argues that Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) requires that disability be evaluated as of the date of the reconsideration order. Further, it argues, OAR 436-35-007(9) directs that the arbiter's report is to be used to rate permanent disability unless a preponderance of the evidence indicates otherwise. Therefore, it contends, the Referee erred in refusing to consider post-closure findings from the attending physician and other medical examiners of record in rating claimant's permanent impairment.

A medical report not considered by the Appellate Unit pursuant to ORS 656.268(5), may be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B); 656.268(7); 656.283(7)) are applicable. Cynthia L. Luciani, 45 Van Natta 1734 (1993). Medical evidence which concerns a worker's permanent disability, regardless of when it is generated, may be considered pursuant to ORS 656.283(7) provided that it is relevant to claimant's permanent disability as of the date of the reconsideration order. Safeway Stores, Inc. v. Smith, supra; Gary C. Fischer, 46 Van Natta 60 (1994), on recon 46 Van Natta 221 (1994).

However, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994) (Board violated ORS 656.245(3)(b)(B) by receiving and considering impairment findings of an independent medical examiner). Impairment findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. OAR 436-35-007(8); Alex J. Como, 44 Van Natta 221 (1992). Turning to the disputed reports, we make the following conclusions.

In the instant case, a medical arbiter, Dr. Gritzka, was appointed. Thus, the prohibition of ORS 656.268(7) is applicable. Dr. Brown's December 22, 1992 medical report and Dr. Button's April 23, 1993 medical report are reports from non-attending physicians. Because Dr. Wilson did not ratify Drs. Brown and Button's impairment findings, the Referee properly declined to consider their reports to rate claimant's permanent impairment. ORS 656.245(3)(b)(B); Koitzsch, supra; Como, supra.

Dr. Wilson's August 26, 1992, November 18, 1992, and January 4, 1993 medical reports are based on examinations that took place before issuance of Dr. Gritzka's February 9, 1993 medical arbiter report, as well as the March 8, 1993 reconsideration order. Therefore, those reports may be considered as they pertain to claimant's permanent disability as of the date of the reconsideration order. ORS 656.283(7); Safeway Stores, Inc. v. Smith, supra; Fischer, supra. Thus, claimant's permanent disability is to be rated considering both Dr. Wilson's post-closure reports and Dr. Gritzka's arbiter's report.

Unless a preponderance of the evidence from the attending physician indicates otherwise, the arbiter's report is to be used to rate permanent disability. OAR 436-35-007(9). Here, although Dr. Wilson saw claimant for several follow-up post-operative visits, he never performed a closing examination nor authored/ratified a report regarding claimant's impairment findings. Consequently, based on Dr. Gritzka's medical arbiter report, we find that claimant's permanent impairment is 39 percent. Under these circumstances, we agree with the Referee's decision to affirm the reconsideration 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 $450, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 6, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $450, to be paid by the self-insured employer.

In the Matter of the Compensation of
BARBARA J. HAYES, Claimant
WCB Case Nos. 92-08671 & 92-08047
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Nielsen's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for her current low back condition; and (2) upheld the self-insured employer's denial of claimant's injury claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant injured her back while changing her shoes during a break from work. Concluding that claimant's injury did not occur in the course and scope of her employment, the Referee found that claimant had not established a compensable injury. We disagree.

In Leo Polehn Orchards v. Hernandez, 122 Or App 241 (1993), the court explained that the variety of claims brought under the Workers' Compensation Act has led to the articulation of several specialized concepts and ways of categorizing employee activities that help to determine whether an injury has sufficient "work connection" to make it compensable. One of the categories cited by the court involved "personal comfort" activities that occur on the employer's premises. Relying on Clark v. U.S. Plywood, 288 Or 265, 266-67 (1980), the court acknowledged that injuries arising out of such activities at

work may be compensable. The court also reasoned that the basic underpinning of such cases is that it is the obligation of employment to be on the premises that creates the risk of injury to the employer. Leo Polehn Orchards, supra.

The "personal comfort doctrine" has been defined in 1A Larson, Workmens's Compensation Law 5-5, §21.00 (1993). Larson's provides that:

> "Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the extent of departure is so great that an intent to abandon the job temporarily may be inferred, or unless, in some jurisdictions, the method chosen is so unusual and unreasonable that the conduct cannot be considered an incident of employment."

Although the Clark Court accepted the concept of the personal comfort doctrine, it also redefined the test for compensability under the doctrine. In Clark, the Court held that compensability of on-premises injuries sustained while engaged in activities for the personal comfort of the employee can best be determined by asking whether the conduct was expressly or impliedly allowed by the employer. The Court determined that conduct which an employer expressly authorizes and which leads to the employee's injury should be compensated whether it occurs in a directly related work activity or in conduct incidental to the employment. Furthermore, where an employer impliedly allows conduct, compensation should be provided for injuries sustained in that activity. The Court noted that an employer's acquiescence could be shown by showing common practice or custom in the work place. Clark, supra, 288 Or at 266-267.

In the present case, we conclude that the personal comfort doctrine is applicable. We agree with that portion of the Referee's order that found that the medical evidence establishes that claimant injured her back in February 1992, while changing her shoes at work. Furthermore, claimant testified that she was changing her shoes to relieve and relax her back (i.e., for her own personal comfort).

After reviewing the record, we also conclude that claimant was obligated to be on the premises at the time the injury occurred. Specifically, claimant testified that she was working a 2 p.m. to 11 p.m. shift as a retail clerk for the employer, and she injured her back at approximately 8 p.m. Claimant had eaten "lunch" and was no longer on a break (although she was "off the floor") at the time she was injured. Claimant's back had begun to bother her and she told her co-workers that she was going upstairs to her employee locker, in order to change her shoes. Consequently, we find that claimant was required to be on the premises at the time the injury occurred.

Moreover, we conclude that the employer impliedly allowed the conduct (changing shoes) which led to claimant's injury. Claimant testified that she had been changing her shoes at work for three to four years, and the change of shoes helped her get through her shift. Claimant also testified that the employer was aware that she did so. Finally, claimant was using a locker provided by the employer on its premises. Therefore, we conclude that the employer acquiesced in the on-premises conduct.

Under the circumstances, we find that claimant's injury is compensable under the doctrine expressed in Clark, supra. Therefore, claimant has proven that her injury arose out of and in the course of employment, and the relationship between the injury and the employment is sufficient to allow compensability. ORS 656.005(7)(a); Rogers v. SAIF, 289 Or 633 (1980).

Responsibility

Having found that claimant has established compensability, we next determine responsibility for the low back condition.

Claimant's compensable injury in 1986, diagnosed as a low back strain, was accepted by Liberty. The claim was closed in April 1987 by Notice of Closure, with an award of temporary disability only.

Following claimant's work injury with the employer in February 1992, Dr. Howell, osteopath, examined claimant on behalf of the self-insured employer. Following his June 23, 1992 examination, Dr. Howell noted that claimant had not received any treatment for her back for over two years prior to the February 1992 incident. Dr. Howell stated that whatever condition was present in February 1992 "appeared to have been of abrupt onset," occurring while claimant put on her shoes.

Dr. Bartell, claimant's treating physician, reviewed Dr. Howell's report and concurred with it. Furthermore, in an August 19, 1992 letter, claimant's counsel described claimant's 1992 work activities and the shoe changing incident. Dr. Bartell agreed that the work activity described by claimant's counsel was the major contributing cause of her need for treatment on February 13, 1992 and thereafter.

Under the circumstances, we find no persuasive reason not to defer to the opinion of claimant's treating doctor. We find that the opinion of Dr. Bartell, as supported by Dr. Howell's opinion, establishes that the February 1992 incident was the major contributing cause of claimant's need for treatment for her resultant condition. See ORS 656.005(7)(a)(B). Consequently, we find that claimant sustained a "new compensable injury." ORS 656.308(1). Therefore, responsibility for claimant's low back condition shifts from Liberty to the self-insured employer. See ORS 656.308(1); SAIF v. Drews, 308 Or 1 (1993).

Inasmuch as claimant has finally prevailed over the employer's compensability denial, an attorney fee is available for claimant's counsel's services. 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $2,250 is a reasonable assessed fee for claimant's counsel's efforts at hearing. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issues, and the value of the interest involved. We note that, because claimant's appellant's brief was rejected on review as untimely, no attorney fee is available for claimant's counsel's services on review. See e.g. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated March 23, 1993 is reversed in part and affirmed in part. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing, claimant's counsel is awarded an assessed attorney fee of $2,250, to be paid by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARY K. KARPPINEN, Claimant
Own Motion No. 93-0650M
OWN MOTION ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Liberty NW Ins. Corp., Insurance Carrier

Claimant requested reconsideration of our December 3, 1993 Own Motion Order. In that order, we reopened claimant's April 10, 1987 right knee injury claim for own motion relief. In her request for reconsideration, claimant asserted that, because the insurer accepted her chondromalacia condition as part of the 1987 knee injury claim by a Stipulated Settlement on February 17, 1993, she should have a new aggravation period that would begin five years from the date of the first closure of the chondromalacia condition. Therefore, claimant asserts, her claim should be reopened as an aggravation claim under ORS 656.273 rather than an own motion claim under ORS 656.278.

In order to consider claimant's motion, we withdrew our December 3, 1993 order and granted the insurer an opportunity to respond. The insurer's response has been received, as has claimant's reply to that response. Accordingly, we proceed with our reconsideration.

The following is a summary of the facts in this case. On April 10, 1987, claimant injured her right knee when she fell at work. The insurer accepted the claim as disabling. The claim was initially closed by Notice of Closure on July 27, 1987. The claim was subsequently reopened and patellar chondromalacia was noted during an August 20, 1991 surgery performed by Dr. Weintraub, claimant's treating orthopedist. The claim was last closed on February 7, 1992 by Notice of Closure. Claimant's aggravation rights expired on July 27, 1992.

Claimant requested reconsideration of the February 7, 1992 Notice of Closure. On August 27, 1992, an Order on Reconsideration issued which reduced the award of scheduled permanent disability that had been awarded by the February 7, 1992 Notice of Closure. On February 17, 1993, the parties entered into a stipulation in which, among other things, the insurer agreed to: (1) reinstate the scheduled permanent disability award awarded by the February 7, 1992 Notice of Closure; and (2) accept the condition of patellofemoral chondromalacia grade III.

On August 30, 1993, Dr. Weintraub requested authorization to perform a partial patellectomy on claimant. On October 1, 1993, Dr. Gripekoven, orthopedist, examined claimant for the insurer and recommended a different surgical procedure for claimant's right knee, the need for which he related to claimant's 1987 work injury. On October 29, 1993, Dr. Weintraub concurred with Dr. Gripekoven's report.

In her request for reconsideration, claimant argued that the chondromalacia condition was not accepted as part of the claim until the 1993 stipulation. Therefore, claimant argued, her aggravation rights regarding the chondromalacia condition should run for five years from the first closure of that condition. In reply to the insurer's argument that the acceptance of the chondromalacia condition as a component of the original injury did not begin a new aggravation period, claimant relied on Donald G. Stacy, 45 Van Natta 2360 (1993), and argued that her five year aggravation rights regarding the chondromalacia condition should run from August 20, 1991, the date the condition was identified by surgery. Claimant does not prevail on either of her arguments to extend her aggravation rights on the basis of the acceptance of the chondromalacia condition as part of the 1987 injury claim.

Claimant interprets Stacy, supra, to hold that aggravation rights run from the "date of injury" and the "date claimant first sought treatment for the condition." Based on that interpretation, claimant reasons that she first sought treatment for the chondromalacia condition as of the August 20, 1991 surgery. Therefore, she argues, her aggravation rights for the chondromalacia condition should run from that date.

Claimant misinterprets the Board's decision in Donald G. Stacy, supra. In Stacy, the Board determined the "date of injury" for an initial occupational disease claim for purposes of determining aggravation rights. Specifically, we disavowed our holding in Robert E. Wolford, 45 Van Natta 435 (1993), which had 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. Relying on Papen v. Willamina Lumber Company, 123 Or App 249 (1993), we held that, for the 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, claimant makes no contention that the chondromalacia condition is either a new injury or a new occupational disease. In any event, the record would not support such a contention. Instead, claimant agrees that the chondromalacia condition is a component of the 1987 injury claim. Stacy, supra, and Papen, supra, the case on which Stacy relied, both dealt with the determination of aggravation rights regarding initial occupational disease claims, not a consequential claim that resulted from an initial work injury or occupational disease. Neither case supports claimant's argument for extended aggravation rights based on the subsequent acceptance of a condition related to the initial 1987 injury.

In addition, we recently addressed an argument similar to claimant's argument for extended aggravation rights in Mark D. Fuller, 46 Van Natta 63 (1994). There, the claimant sustained a compensable low back injury in 1979. The aggravation rights on that claim had expired and the claim was in own motion status. In 1992, the insurer denied several conditions, including the claimant's psychiatric condition. However, an Opinion and Order subsequently set aside the denial of the psychiatric condition, determining that it was compensable as a consequence of the 1979 back injury. That order was not appealed and became final by operation of law. At that time, claimant's claim remained opened by virtue of an earlier own motion order. The claimant requested that the Board "relinquish" its jurisdiction over his claim and refer the claim to the Department for issuance of a Determination Order in light of his current compensable psychiatric condition.

We denied the claimant's request, reasoning that a consequential condition, once found compensable, is treated as an aggravation. Fuller, supra at 64. However, we reasoned that, if a claimant's aggravation rights have expired, the "processing in accordance with law" is different. Id. The same reasoning applies in the present case.

ORS 656.273(4)(a) provides that a claim for aggravation of a disabling injury must be made within five years of the first claim closure. ORS 656.278(1)(a) confers exclusive jurisdiction on the Board for "aggravation" claims filed after the five year period has expired. Inasmuch as the aggravation rights on claimant's 1987 injury claim have expired, the Board has exclusive own motion jurisdiction over this claim. See Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988).

Furthermore, effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in our own motion capacity. Independent Paper Stock v. Wincer, 100 Or App 625 (1990); Charles W. Roller, 44 Van Natta 1001 (1992). Once a claimant's claim is in own motion status, his or her only entitlement to future monetary compensation is restricted to time loss benefits under limited circumstances, although he or she is entitled to lifetime medical benefits related to the compensable injury. ORS 656.278(1)(a).

Claimant's argument that she is entitled to an additional five year period of aggravation rights based on the insurer's subsequent acceptance of the chondromalacia condition as part of the 1987 injury claim would circumvent the legislature's explicit directive limiting a worker's future monetary compensation to time loss benefits once the worker's aggravation rights have expired and the claim is in own motion status. ORS 656.278(1)(a); Independent Paper Stock v. Wincer, supra; Mark D. Fuller, supra.

Consequently, for the above reasons, we find that claimant is not entitled to an extended five year period of aggravation rights based on the insurer's acceptance of the chondromalacia condition as part of the 1987 right knee injury claim. Accordingly, our December 3, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 3, 1993 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUTH NUTE, Claimant
WCB Case No. 92-11692
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Mongrain's order that: (1) found that claimant's right wrist carpal tunnel syndrome (CTS) injury claim was barred by a previous settlement agreement; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right CTS. On review, the issues are claim preclusion and compensability.

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

On review, claimant contends that the December 1991 Disputed Claim Settlement Agreement (DCS) only settled the compensability of her low back condition. SAIF, on the other hand, argues that because the compensability of claimant's CTS injury claim was "raisable" at that time, the Referee properly granted SAIF's motion to dismiss the issue of a specific injurious work-related event from the hearing proceeding.

Subsequent to the Referee's order in this case, in Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), the court reversed a Board order which had held that a claimant's wrist nerve condition was not barred by a previous stipulation unless the claimant "intended to waive that right when she signed the stipulation." The court disagreed with our analysis. Instead, relying on Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), the court explained that the "correct inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement." Stoddard, supra, 126 Or App at 73. The court reasoned that, because the claimant's nerve condition had been diagnosed prior to the date the parties entered into the stipulation agreement (in which the parties agreed that the claimant's accepted wrist claim would remain closed), the claimant's nerve condition was an issue that could have been raised before that date. Id. Therefore, the court concluded, the claimant's wrist condition claim was barred by the settlement agreement.

In the instant case, claimant's right wrist CTS injury claim is similarly barred by the December 1991 "Disputed Claim Settlement." Claimant filed an 801 form alleging she sustained injuries to the "right hand and lower back" on July 4, 1991. SAIF denied the claim and claimant requested a hearing. Claimant was first diagnosed with "carpal tunnel-like symptoms" in November 1991. Thereafter, in December 1991, claimant and SAIF entered into a DCS wherein SAIF contended that "claimant did not injure herself while at work on July 4, 1991." The DCS further concluded that SAIF's denial, as supplemented by the DCS, "shall remain in full force and effect," and that the agreement "settle[s] all issues raised or raisable at this time[.]"

Therefore, because claimant's CTS was diagnosed prior to the date the parties entered into the DCS, claimant's CTS injury claim was an issue that could have been raised before that date. Furthermore, we note that the DCS provided that the denial (which pertained to claimant's right hand and lower back claim) remained in full force and effect. Under these circumstances, we find that claimant is precluded from litigating the issue of the compensability of her CTS on an injury theory. Consequently, the Referee properly upheld SAIF's denial of claimant's right wrist CTS injury claim. See Stoddard, supra; Seney, supra.[1]

ORDER

The Referee's order dated June 17, 1993 is affirmed.

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[1] While Board Member Hall respectfully disagrees with the holdings in Seney, supra, and Stoddard, supra, he is legally bound to follow the holdings of the Court of Appeals where they are factually applicable. Finding no factual basis to distinguish the instant case from Seney and Stoddard, Board Member Hall joins in this decision.

In the Matter of the Compensation of
JANE A. VOLK, Claimant
WCB Case No. 92-06678
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Thye's order that declined to award her counsel an approved attorney fee. On review, the issue is entitlement to an approved attorney fee. We reverse.

FINDINGS OF FACT

Claimant was awarded 20 percent unscheduled permanent disability by an October 23, 1991 Determination Order. The employer paid the full award to claimant.

Claimant requested reconsideration of the Determination Order. On June 9, 1992, an Order on Reconsideration reduced claimant's award to 11 percent. Claimant requested a hearing on the Order on Reconsideration. In addition, the employer asserted entitlement to offset overpaid compensation.

In lieu of a hearing, the parties entered into a stipulation which, among other things, reinstated the Determination Order award of 20 percent unscheduled permanent disability. In addition, the parties agreed to submit the issue of claimant's counsel's entitlement to an approved attorney fee to the Referee for resolution. The stipulation was signed by the Referee on March 5, 1993.

CONCLUSIONS OF LAW AND OPINION

Relying on Ralph D. Stinson, 44 Van Natta 1274 (1992), the Referee concluded that because "increased" compensation was not awarded by the stipulation, claimant was not entitled to an approved attorney fee. After further examination of the Board's holding in Stinson, supra, and in light of the apparently contrary holding in Judy A. Jacobson, 44 Van Natta 2393, on recon 44 Van Natta 2450 (1992), we conclude that the Stinson rationale was in error.

In Stinson, supra, the claimant requested review of an Order on Reconsideration that had awarded him 3 percent unscheduled permanent disability. Prior to the hearing, the insurer stipulated that the claimant was entitled to at least the 8 percent previously awarded by the Determination Order, which had already been paid. The referee increased the claimant's award to 15 percent and awarded the claimant an attorney fee based on the 12 percent difference between that award and the 3 percent awarded by the Order on Reconsideration.

On review, in Stinson, the insurer argued that, due to its pre-hearing stipulation that the claimant was entitled to an award of 8 percent, the Referee's order only increased the claimant's award by 7 percent. We agreed, concluding that, under those circumstances, "no overpayment existed to be offset against the 'increased compensation' created by the Referee's order." 44 Van Natta at 1275.

In Judy A. Jacobson, supra, a Determination Order awarded the claimant 27 percent unscheduled permanent disability. The insurer paid this award in full. The claimant requested reconsideration and her award was reduced to 10 percent by Order on Reconsideration. The claimant requested a hearing and the Referee increased the award to 17 percent. The insurer requested review, contending that the claimant was only entitled to the 10 percent awarded by the Order on Reconsideration. On review, the Board found that the claimant was entitled to 25 percent unscheduled permanent disability.

The Jacobson insurer argued that since it had previously paid the claimant the 27 percent award granted by the Determination Order, neither the Referee nor the Board "increased" the claimant's award and therefore the claimant's counsel was not entitled to an approved attorney fee. The Board rejected this argument, reasoning that both the Referee and the Board increased the claimant's award in that it was established that the claimant was entitled to a 25 percent award. In other words, the insurer's existing overpayment was reduced and the insurer's ability to offset its overpayment against future benefits was limited. Id. at 2451. In addition, the Board noted that adopting the insurer's argument would contravene OAR 438-15-085(2) which provides that attorney fees authorized to be paid out of compensation shall not be subject to any offset based upon a prior overpayment of compensation to claimant.

The Jacobson Board distinguished Stinson, supra, on the basis that there was no pre-hearing stipulation with regard to the least amount of permanent disability that the claimant was entitled to. Finally, the Board authorized an offset equal to the attorney fee awarded by the Referee and Board orders against the claimant's future awards of permanent disability.

After further consideration, we find that there is no meaningful distinction between Stinson and Jacobson. The pre-hearing stipulation in Stinson, (that the claimant was entitled to a at least 8 percent) did not change the fact that due to the Order on Reconsideration, the claimant's award at the time of the hearing was only 3 percent. Moreover, we cannot make a meaningful distinction between a Referee's order and a stipulation by the parties, that is ultimately, either directly or indirectly, subject to approval by the Referee. See e.g. International Paper Company v. Pearson, 106 Or 121 (1991).

In Stinson, as in Jacobson, the Referee's decision to increase the claimant's award to 15 percent established the claimant's entitlement to that amount, thereby reducing the insurer's overpayment and limiting its ability to offset its overpayment against the claimant's award. For the reasons set forth in Jacobson, we would therefore conclude that the Referee's order in Stinson increased the claimant's award by 12 percent (the difference between the 3 percent award by the reconsideration order and the 15 percent awarded by the Referee) and the claimant's counsel would be entitled to an approved attorney fee based on that increase.

In light of the aforementioned reasoning, we disavow our decision in Stinson in favor of our analysis in Jacobson, which controls the present case.

Here, the Order on Reconsideration awarded claimant 11 percent unscheduled permanent disability. By stipulation of the parties, claimant's award was increased to 20 percent. While the 20 percent had previously been paid by the insurer, the parties' stipulation established claimant's entitlement to an award of 20 percent, thereby eliminating the insurer's previously existing permanent disability overpayment and extinguishing the insurer's ability to offset any such overpayment against future benefits.

In other words, through her attorney's efforts, claimant's 20 percent unscheduled permanent disability award (as granted by a Determination Order) has been reinstated. As a result of this reinstatement, the Order on Reconsideration award of 11 percent has been "increased" to the previously granted 20 percent. Although as a practical matter claimant had already received her entire 20 percent award, 9 percent of that award was subject to offset against future permanent disability awards until reinstatement of the total award.

Inasmuch as claimant's counsel has been instrumental in obtaining a "substantive increase" in claimant's permanent disability, counsel is entitled to an "out-of-compensation" attorney fee. ORS 656.386(2); OAR 438-15-040. The question now is how may claimant's attorney secure payment in view of the fact that claimant has already received the full amount of the compensation award, including the amount of the approved fee.

In Jacobson, we directed the carrier to pay claimant's attorney the fee amount, recognizing that this would create an overpayment (in the amount of the fee), if the full amount of the permanent disability award had already been paid. We authorized the carrier to recover such an overpayment as an offset against any future awards of permanent disability.

We believe that in creating an overpayment of compensation, the Jacobson Board erred. The court has reminded us that we are without authority to create such overpayments. See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Furthermore, by doing so, the Board essentially made the insurer responsible for the claimant's attorney fee, when an "out-of-compensation" fee rather than an assessed fee had been awarded.

The unstated policy behind the rationale we expressed in Jacobson was to encourage legal representation for all injured workers. We, no less now than before, support the proposition that injured workers should seek legal counsel when presenting their claims through the litigation process. See OAR 438-06-100(1). Likewise, we share the goal of the Jacobson holding to establish a procedure which attempts to insure that claimants' attorneys shall receive the fees to which they are indisputably entitled. However, where we part company with Jacobson is the method designed to achieve these laudable goals.

Where, as here, claimant's attorney is primarily securing a "substantive" right to previously paid compensation, the Jacobson rationale implements a procedure which insures that claimants' attorneys' shall receive the "out-of-compensation" fee by requiring the employer to pay the fee directly to the attorney even though the compensation has already been paid to the attorney's client. Since this procedure unquestionably necessitates the creation of an "administrative overpayment" by requiring the employer to pay additional compensation to which claimant is not entitled, the procedure cannot withstand legal scrutiny. See Lebanon Plywood v. Seiber, supra. Moreover, such a procedure would make the employer responsible for the attorney fee, an action for which there is no statutory authority. See Johnson v. Capitol Car Wash, 127 Or App 49 (1994).

Accordingly, in lieu of the procedure set forth in Jacobson for recovery of an "out-of-compensation" attorney fee where the compensation has already been paid, we implement the following procedure. We consider this procedure to be in accordance with statutory and administrative prerequisites, as well as consistent with claimant's retainer agreement.[1]

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[1] The retainer agreement provides that "[i]f my attorney is instrumental in obtaining compensation for me, with or without a hearing, I agree to pay my attorney a fee authorized by and the maximum amount allowed by Board rules and by law. I agree that any attorney fee awarded from my compensation is a lien upon my compensation. . . ."

Claimant's attorney shall be awarded the "out-of-compensation" fee. Since the compensation has already been paid to claimant, her attorney must first seek recovery of the fee directly from claimant.

Our approval of this attorney fee also represents a lien upon claimant's compensation. ORS 656.388(2); OAR 438-15-010(3). Therefore, in the event that the attorney's efforts to recover the fee directly from claimant are unsuccessful, a question arises regarding the manner in which this lien may be fully satisfied. In the interests of establishing an efficient and expeditious manner for satisfaction of this lien, we implement the following procedure.[2]

Claimant's attorney may present written documentation of the attorney's collection efforts to the employer. This documentation, which shall be accompanied by claimant's attorney's affidavit certifying to the truth and accuracy of the representations contained therein, shall establish: (1) the amount of the unpaid attorney fee; and (2) that claimant has failed to fully satisfy the remaining balance due on the unpaid fee within 14 days from claimant's attorney's written demand to claimant for payment.

In addition to this documentation, claimant's attorney should request that the employer reimburse the attorney for any unpaid balance owing from claimant concerning the fee. This reimbursement shall be paid by the employer directly to claimant's attorney from any future permanent disability awards granted on the claim.

If claimant's attorney satisfies the aforementioned procedural requirements, the employer shall be required to first pay any of claimant's future permanent disability awards on the claim to the attorney in an amount sufficient to satisfy the remaining balance due on the unpaid attorney fee. If claimant's initial future award is insufficient to fully satisfy the unpaid attorney fee, this Board authorization of the lien shall continue until claimant's attorney's fee is fully paid. Once the unpaid attorney fee is fully satisfied, the employer shall pay the remaining future permanent disability awards to claimant in the usual fashion.

As with the method prescribed in Jacobson, this procedure attempts to secure claimant's counsel's right to an attorney fee.[3] Admittedly, this method necessitates certain actions on claimant's attorney's part to obtain that fee. Moreover, full and immediate recovery of the attorney fee may well be delayed. Nonetheless, for the reasons previously discussed, this method is in accordance with

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[2] The dissent contends that the implementation of this "lien recovery" procedure represents invalid rulemaking. We disagree with that characterization.

This procedure has been offered only as a discretionary option to claimant's attorney for recovery of the fee. If claimant's attorney chooses not to exercise this option, the procedure is of no effect. In light of its permissive nature, we do not consider implementation of this procedure for this particular case to consistent rulemaking.

Secondly, this procedure is merely designed to assist the attorney and the employer in processing future compensation claims in the event that the attorney fee is unpaid and claimant's attorney wishes to execute upon the lien. In other words, we are merely establishing the manner and fixing the extent of claimant's attorney's lien upon claimant's future compensation. Such an action is entirely consistent with our statutory authority. See ORS 656.388(2). Although the establishment of such a procedure may be authorized through formal rulemaking, it may also be implemented on a case-by-case basis. Trebesch v. Employment Division, 300 Or 264 (1985); SAIF v. Campbell, 113 Or App 93, 96 (1992).

Finally, this procedure may well form the basis for future rulemaking proposals. Nevertheless, in the meantime, this claimant's attorney is provided with an optional procedure for collection of an unpaid fee which, if exercised, will provide the employer with instructions concerning its claim processing obligations. Since such a procedure is in accordance with our statutory authority and furthers the objective of establishing an efficient payment schedule for the distribution of claimant's future compensation with reduced litigation, we consider this action to be a worthwhile endeavor.

[3] The dissent also argues that our decision conflicts with another portion of the Jacobson reasoning in that we are essentially applying an "offset" to claimant's "out-of-compensation" attorney fee in contravention of OAR 438-15-085(2). We disagree. Had we held that claimant's attorney was not entitled to a fee because all of the compensation had already been paid to claimant, such a holding would have been contrary to the administrative rule, as well as the Jacobson rationale. However, as explained in our decision, we have reached just the opposite conclusion. In other words, claimant's attorney is entitled to an "out-of-compensation" attorney fee, which is not offset by claimant's prior receipt of the "increased" compensation.

statutory and administrative requirements.[4] Finally, rather than directing the employer to pay an "administrative overpayment" (an action which we are without authority to take), we are authorizing the employer to distribute a portion of claimant's future permanent disability awards to her attorney (an action which is both within our authority and consistent with claimant's retainer agreement).

We take issue with the dissent's contention that as a result of this decision "claimant's counsel does not actually get paid his attorney fee." Admittedly, we prefer to assume that the large majority of workers and employers voluntarily honor their legal obligations. Inasmuch as claimant expressly agreed to share a portion of her compensation with her attorney and since we have directed her to do so by this order, we assume that she will fulfill her obligations in a manner which is mutually satisfactory to herself and to her counsel.

This "lien recovery" procedure is only designed to offer an alternative "collection" method to a claimant's attorney for securing payment of any "out-of-compensation" fee should the attorney's client fail or refuse to abide by the client's legal obligations. Although the procedure requires certain actions to be taken by a claimant's attorney, we do not consider the procedure to be "cumbersome and time-consuming" as characterized by the dissent. This procedure is far less complicated than garnishment or other collection procedures which are available through the civil court system for recovering unpaid judgments or outstanding liens. Moreover, this procedure is no more cumbersome than the preparation / execution of hearing requests, certificates of mailing, correspondence, or statement of services / petitions for attorney fees which are routinely filed on a daily basis with this forum.

As with any attorney who is contemplating the initiation of an action to recover an unpaid fee, that attorney must evaluate the advisability of taking such an action. Our decision is not intended to require an attorney to take such measures. In fact, as previously explained, this action will likely not be necessary because we expect that this claimant will satisfy her lawful obligation to her counsel. This procedure is merely designed to provide an attorney with a method for recovering an unsatisfied fee should the need arise, and if that attorney wishes to exercise this discretionary option.

Requiring a carrier to pay the attorney fee and then authorizing the recovery of the "administrative overpayment" we have thus created is understandably less discomforting to claimant's attorney than the alternative, which was to recognize that the fee is owed by claimant. Nevertheless, that attorney fee is not the financial obligation of the carrier. Moreover, the creation of such an "overpayment" would conflict with the letter and the spirit of the holding in Seiber. We disagree with the dissent's contention that Seiber is not controlling.

Here, as in Seiber, at the time claimant requested a hearing from a closure order, she had already received all the compensation to which she was substantively entitled. Thus, regardless of whether the sums involved are characterized as an "attorney fee" or "additional compensation," any order directing the payment of such further benefits and authorizing the future recovery of such benefits would conflict with the Seiber prohibition against the creation of "administrative overpayments."

This reasoning is also not inconsistent with our holding in Nancy O'Neal, 45 Van Natta 2081 (1993). In O'Neal, when the claimant (through her duly retained attorney of record) requested a hearing seeking additional benefits, the carrier had not paid all the compensation to which the claimant was entitled. Prior to hearing, when the carrier concluded that the claimant was due additional benefits, it paid all of this previously unpaid compensation directly to the claimant without notifying the claimant's attorney or accounting for the attorney's "out-of-compensation" fee. In light of the carrier's unilateral action while the matter was pending before the Board, and since the claimant's attorney could have taken no further action to prevent such an action, we held that it was not inequitable to require the carrier to pay the "out-of-compensation" fee directly to the claimant's attorney and seek recovery of the overpayment against the claimant's future permanent disability compensation. We reasoned that, to do otherwise would not only be inconsistent with the full disclosure requirements of the litigation process, but could also lead to instances of "gamesmanship" by permitting carriers to pay disputed compensation directly to represented claimants without accounting for the claimant's attorney's rightful share.

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[4] Any claim for payment to a claimant's attorney by the claimant so approved by the referee, Board, or court shall, in the manner and to the extent fixed by the referee, Board, or such court, be a lien upon compensation. ORS 656.388(2). An approved fee awarded or allowed to an attorney representing a claimant shall be a lien upon the claimant's compensation. OAR 438-15-010(3).

For the reasons expressed in O'Neal and above, we are of the opinion that we are authorized to require litigants appearing before this forum to communicate through their respective legal representatives. Furthermore, O'Neal stands for the proposition that, when a carrier neglects to follow this basic course of conduct and pays disputed compensation to a claimant without accounting for that claimant's attorney's rightful share, we are likewise permitted to direct that carrier to pay that fee to the claimant's attorney. Without question, an overpayment has been created through such a directive. Nevertheless, since that overpayment was necessitated by a carrier's unilateral action at a time when the dispute was subject to our authority, we conclude that the overpayment has essentially been created by the carrier, not by this forum.

This particular situation resembles superficially the situation present in O'Neal. Yet, the policy concerns which formed the basis of our holding in O'Neal, are absent. No additional compensation was due claimant at the time of the filing of her hearing request or thereafter. Since the carrier had already paid all of the compensation to which claimant was substantively entitled (in compliance with an order, in fact), any further directive requiring the carrier to pay claimant's attorney a fee would run counter to the Seiber holding because we would be creating an administrative overpayment.

Even were we to agree with the dissent that the prospect of recovering the attorney fee is fairly described as "speculative," the Board would have no authority to require the employer to bear the risk of nonrecovery. Claimant has already been paid the compensation. Any risk of nonrecovery from claimant must be borne by claimant's attorney.

In conclusion, we hold that claimant's attorney is entitled to a fee payable from claimant's "increased" compensation. In accordance with statutory and administrative requirements (as well as claimant's retainer agreement), claimant's attorney shall seek recovery of that fee from claimant. Should those recovery efforts prove unsuccessful, claimant's attorney may elect to seek to recover any unpaid portion of the fee from claimant's future permanent disability awards in the manner detailed above.

ORDER

The Referee's order dated April 21, 1993, is reversed. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation (9 percent unscheduled permanent disability) created by the parties' stipulation, not to exceed $2,800. This fee shall be recovered either: (1) directly by claimant's attorney from claimant; or (2) indirectly from claimant's future permanent disability awards on this claim provided that claimant's attorney submits the required documentation to the insurer in accordance with the procedures set forth in this order.

Member Hall and Member Gunn dissenting.

The majority finds that claimant's counsel was instrumental in obtaining a "substantive increase" in claimant's permanent disability and is therefore entitled to an approved attorney fee. However, the majority concludes that the approved attorney fee must come either from claimant or from claimant's future permanent disability and not from the carrier. Because we believe that the carrier should be directed to pay the approved attorney fee, we dissent.

The majority concedes that claimant's counsel was instrumental in obtaining claimant increased permanent disability and concedes that counsel is entitled to an attorney fee. In fact, the majority opinion follows the rationale expressed in Judy A. Jacobson 44 Van Natta 2393, on recon 44 Van Natta 2450 (1992), in determining that claimant's counsel did in fact obtain a benefit for claimant.

Despite concluding that counsel is entitled to an approved attorney fee, the majority goes on to find that claimant's counsel does not actually get paid his attorney fee. Rather, he must either obtain it from claimant or wait until claimant is awarded additional permanent disability benefits in the future. While the majority states that it "supports" the proposition that injured workers should have legal representation throughout the litigation process, its solution to this issue clearly has the opposite effect.

Under the majority's procedure, whether or not claimant's counsel will actually get a fee is speculative at best. Claimant's attorney will likely be unable to get his/her fee from the claimant, so the only option will be to hope claimant gets an award in the future so that he/she can finally get paid. This option requires a further process that claimant's counsel must go through in order to secure the attorney fee (that has already been earned) if claimant is eventually awarded further permanent disability. Claimant's counsel must show: proof that the fee was demanded from claimant; evidence that claimant received the demand prior to asking the carrier for the fee; ledger sheets showing payments, if any, that claimant has made toward satisfaction of the fee; and an affidavit describing collection efforts and certifying the accuracy of all submitted documents.[1]

This scenario would get even further complicated if claimant is represented by different counsel at the time he/she is awarded further permanent disability benefits. The carrier would be put in the position of acting as a mediator to determine if claimant's former attorney or current attorney is paid first.

Given the speculative nature of obtaining payment from the carrier, in conjunction with the cumbersome and time-consuming procedure that must be followed, the incentive for a claimant's attorney to pursue this type of case is almost nonexistent. The result will be that most injured workers will not appeal the reconsideration order and those awards, however incorrect will stand. It is unrealistic to expect attorneys to work with only a "speculative" and "delayed" hope of getting an attorney fee. Particularly since the approved attorney fee in most cases, will be a small amount. Although the majority indicates that it is in favor of legal representation for injured workers, its decision will go far to eliminating such representation in permanent disability cases.

The majority's decision also runs afoul of some of the reasoning that was expressed in Jacobson. In particular, the Board noted that not allowing claimant's counsel a fee would contravene OAR 438-15-085(2) which provides attorney fees authorized to be paid out of compensation cannot be subjected to any offset based on a prior overpayment of compensation to claimant. Jacobson, supra at 2451. The majority authorizes the attorney fee, but then relies on the fact that the compensation had previously been paid to claimant to determine that claimant's counsel does not get paid a fee at that time. This basically has the effect of protecting the insurer against an overpayment at the expense of claimant's counsel. This is the type of situation that OAR 438-15-085(2) tries to avoid.

The majority cites Lebanon Plywood v. Seiber, 113 Or App 651 (1992) for the proposition that the Board lacks the authority to direct the carrier to pay claimant's counsel on the basis that it would create an administrative overpayment. In Seiber, the court held that the Board did not have the authority to direct a carrier to pay the claimant procedural temporary disability benefits when he was not substantively entitled to such benefits. The issue here is not whether claimant is entitled to additional benefits, it concerns a mechanism to pay claimant's counsel an attorney fee that the attorney is substantively entitled to. The majority's reliance on Seiber is misplaced.

Finally, the majority's decision is at odds with other Board decisions concerning the payment of temporary disability benefits. In Nancy O' Neal, 45 Van Natta 2081 (1993)(Third Order on Remand), we held that the claimant's counsel was entitled to be paid an approved attorney fee directly from the carrier, even though the carrier had previously paid claimant the entire amount of compensation due. We reasoned that since claimant's counsel had taken all the action he could to secure payment of the fee, it was not inequitable to require the carrier to pay claimant's counsel directly and recover the overpayment from future awards of permanent disability. See also Skip W. Ivie, 46 Van Natta 198 (1994).

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[1] Member Hall would also point out that the procedure set out by the majority appears to be rulemaking by case, rather than by formal rulemaking procedure. The Board likely has the authority to promulgate a rule concerning how attorney fees are paid on a case-by-case basis. ORS 656.388(1) & (2); see also SAIF v. Campbell, 113 Or App 93 (1992). However, as the Court noted in Forelaws Energy Fac. v. Siting Council, 306 Or 205, 214 (1988), formal rulemaking permits wider public participation and is particularly appropriate for exercising policymaking authority. Because the majority's procedure for securing payment of a fee (including the production of a ledger and an affidavit by claimant's counsel) will have an affect on all practitioners, the parties in this system would be better served if the formal rulemaking process was invoked before establishing such a procedure, rather than announcing the procedure in this case.

Similarly, we have held that where a claimant's counsel has not taken all action to secure payment of an approved attorney fee, it would be inequitable for the carrier to have to pay claimant's counsel. See Gabriel M. Gonzales, 44 Van Natta 2399 (1992); Kenneth V. Hambrick, 43 Van Natta 1636 (1991). Thus, we have established a policy of allowing claimant's counsel to be paid directly by the carrier, if counsel does not receive payment of the attorney fee through no fault of his/her own.

This is the situation here. Claimant was paid the entire amount awarded by the Determination Order prior to obtaining counsel. There was no action claimant's attorney could take to secure payment of an attorney fee. Our prior decision in Jacobson, supra recognized that fact and was consistent with the above cited cases. Therefore, we would continue to adhere to the entire Jacobson decision and order the carrier to pay claimant's counsel the approved fee at this time.

In the Matter of the Compensation of
GENE C. ADAMS, Claimant
WCB Case No. 93-02513
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Holtan's order that affirmed an Order on Reconsideration that awarded claimant 10 percent (13.5 degrees) scheduled permanent partial disability for loss of use or function of the right foot (ankle) and 32 percent (43.2 degrees) scheduled permanent partial disability for loss of use or function of the left foot (ankle). On review, claimant asserts that the Referee erred in declining to award claimant impairment values for lost ranges of motion in the interphalangeal joints of the toes of his left foot. On review, the issue is extent of scheduled permanent disability.

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

No impairment rating is given for loss of motion in the distal and proximal interphalangeal joints of the second through fifth toes, except in the case of ankylosis. OAR 436-35-160(1), (3). Claimant asserts that ankylosis is defined as stiffness or immobility of a joint. Therefore, he argues, because he testified that he was unable to move the second, third and fourth toes of his left foot, and because those toes are permanently in plantarflexion, he is entitled to an impairment rating under OAR 436-35-160(1) and (3). We disagree.

There is no medical evidence regarding whether claimant suffers from ankylosis in the toes of his left foot. Although claimant testified regarding the condition of his toes, lay testimony alone is insufficient to establish "impairment" under the standards. William K. Nesvold, 43 Van Natta 2767 (1991); see OAR 436-35-005(5).

ORDER

The Referee's order dated June 25, 1993 is affirmed.

In the Matter of the Compensation of
MARGARET E. BECK, Claimant
WCB Case No. 92-16551
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer 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 reverse.

FINDINGS OF FACT

In December 1989, claimant was treated for low back pain after she bent over to water a tree. In August 1990, Dr. Tanabe, surgeon, became claimant's treating physician. Dr. Tanabe attributed claimant's symptoms to a major disc herniation at L4-5, a condition revealed by an MRI scan. (Exs. 6, 7).

On February 28, 1992, claimant again developed low back pain following a work incident. Based on another MRI, Dr. Tanabe indicated that claimant's disc herniation had resolved, but that claimant had "a lot of foraminal stenosis at the lowest three levels on either side." (Ex. 13A). The insurer accepted a low back strain. (Ex. 13).

In early October 1992, claimant returned to Dr. Tanabe for treatment of increased back pain. (Ex. 19). On October 12, 1992, while putting on pantyhose, claimant experienced acute back pain. (Ex. 20). According to Dr. Tanabe, an MRI revealed moderate foraminal stenosis at L4-5. (Ex. 21).

In November 1992, at claimant's request, Dr. Soot examined claimant. Claimant also underwent an examination by Drs. Reimer, neurologist, and Lohman, orthopedic surgeon, at the insurer's request.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proved that the major contributing cause of her need for treatment following the October 1992 incident was the February 1992 injury and, therefore, she carried her burden of proving a compensable aggravation. The insurer challenges this conclusion, asserting that the preponderance of medical evidence shows that claimant's preexisting degenerative condition was the major contributing cause of her need for treatment in October 1992.

According to Dr. Tanabe, the major contributing cause of claimant's increased symptoms in October 1992 was the February 1992 injury. (Exs. 23A, 26). Dr. Tanabe based his opinion on his understanding that, when he initially treated claimant in August 1990, she "had bilateral leg pain, which cleared satisfactorily." (Ex. 26). Dr. Tanabe found that this pain pattern was different after February 1992, in that it consisted of only "unilateral leg pain on the left side[.]" (Id.) Dr. Tanabe also noted that the disc herniation shown on the original MRI "seem[ed] to have resolved on the recent scan." (Id.)

Dr. Tanabe's opinion was contradicted by Dr. Soot. He noted that the MRI showed "evidence of degenerative disc disease especially at the L4-5 and L5-S1 levels" but no "significant compression." (Ex. 22). Dr. Soot found that the major contributing cause of claimant's symptoms was the degenerative disc disease. (Exs. 22, 30-5). Dr. Soot further explained, however, that if claimant had been asymptomatic for a period of time before February 1992 and her symptoms had continued unabated following the February 1992 incident, then the February 1992 incident was more "significant" as a causative factor. (Ex. 30-8, 30-14).

Drs. Reimer and Lohman also found that the major contributing cause of claimant symptoms was her degenerative disc disease. (Exs. 24-5, 29-2). They further found that the strain she sustained in February 1992 had been "relatively minor" and appeared to have "fully resolved without impairment." (Id.) Dr. Soot agreed with the panel's report. (Ex. 27).

In order to prove a compensable aggravation, claimant must show that her compensable injury materially contributed to her worsened condition. Grable v. Weyerhaeuser Company, 291 Or 387 (1981); Fernandez v. M & M Reforestation, 124 Or App 38 (1993). The only opinion providing such proof is from Dr. Tanabe. Although the treating physician, we find persuasive reasons not to defer to his opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Tanabe based his opinion on his understanding that claimant's "pain pattern" was different before the February 1992 injury in comparison to claimant's symptoms following February 1992, in that, after February 1992, she had unilateral leg pain on the left side. We find that the record does not support such an assertion. When Dr. Tanabe initially examined claimant in August 1990, he noted that claimant developed low back pain in December 1989 that radiated down the left thigh. (Ex. 5-1). Dr. Tanabe further stated that, in August 1990, claimant again developed low back pain that extended down the right leg to the ankle. (Id.) At the time that Dr. Tanabe examined her, claimant's right-side pain had resolved and she had symptoms in her low back and left buttocks. (Id.)

When Dr. Tanabe next examined claimant in March 1992, following the February 1992 injury, he noted low back pain that went down the left leg to the knee. (Ex. 10). On October 5, 1992, claimant's symptoms radiated into her right buttocks. (Ex. 19). Similarly, on October 12, 1992, after claimant had pulled on her pantyhose and developed acute back pain, Dr. Tanabe noted "more pain into her right buttocks and sometimes into her lateral thigh on the right side." (Ex. 20).

On October 19, 1992, however, Dr. Tanabe found that the symptoms in claimant's right thigh had "totally disappeared", but there was some radiation of pain into the left buttocks. (Ex. 21). Dr. Tanabe also noted that, before this examination, he had considered a decompression because the MRI had shown foraminal stenosis on the right at L4-5, and claimant's symptoms had been in the right thigh. (Id.)

Thus, the evidence shows that claimant's "pain pattern" was similar before and after the February 1992 injury. Although it was for a short period, claimant experienced symptoms on her right side following the February 1992 incident. Therefore, the history that claimant had only left-sided symptoms after February 1992, which was the basis of Dr. Tanabe's opinion, is inaccurate.

Furthermore, Dr. Tanabe does not explain the effect, if any, on claimant's symptoms of her degenerative disc disease. Dr. Soot and Drs. Reimer and Lohman found that this condition was the major contributing cause of claimant's symptoms and that the February 1992 strain had resolved. Contrary to claimant's assertion, the record does not show that her symptoms continued unabated following the February 1992 incident. (See Exs. 16 and 17).

In conclusion, we find that Dr. Tanabe's history is based on an inaccurate history and not well-reasoned. Therefore, we find that it is not persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Because claimant did not prove that the February 1992 compensable injury was a material contributing cause of her current need for treatment or disability, she did not demonstrate a compensable aggravation.

ORDER

The Referee's order dated June 1, 1993 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
JOANN D. CRAIG, Claimant
WCB Case No. 93-05565
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Howell's order that awarded claimant 22 percent (33 degrees) scheduled permanent disability for the loss of use or function of the left leg (knee), whereas the Order on Reconsideration awarded none. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

In lieu of the finding that the attending physician Dr. Galt agreed with the findings of the Physical Capacity Evaluation (PCE), we find that Dr. Galt did not concur with the PCE impairment findings.

CONCLUSIONS OF LAW AND OPINION

The Referee's scheduled permanent disability award is based on his finding that claimant's attending physician Dr. Galt adopted the impairment findings of the December 3, 1992 PCE. On review, the insurer argues that Dr. Galt did not adopt those findings but, instead, adopted the independent examiners' finding that claimant has no permanent impairment. We agree.

Where no medical arbiter is requested or appointed, only the attending physician at the time of claim closure may make findings regarding a worker's permanent impairment for the purposes of rating disability. See ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1991). Impairment findings made by a consulting physician or other medical provider at the time of closure may be used only if the attending physician concurs with those findings. OAR 436-35-007(8); Marcia R. Leonard, 45 Van Natta 866 (1993).

Here, the attending physician Dr. Galt did not make his own impairment findings. Rather, impairment findings were made by physical capacity evaluators on November 9, 1992, (Ex. 24), and by the insurer's examiners Drs. McKillop and Rich on December 2, 1992, (Ex. 26). The physical capacity evaluators made numerous findings regarding both claimant's residual physical capacities and her permanent impairment due to the compensable left knee injury. They found that claimant made a valid effort during the evaluation, and concluded that she has permanent impairment due to the injury. (Ex. 24-7).

By contrast, the insurer's examiners Drs. McKillop and Rich found that claimant's complaints were "greatly out of proportion" to actual objective findings. They concluded that claimant was overprotective of the knee and that she had no clear-cut evidence of impairment due to the injury. (Ex. 26-7).

Subsequent to both evaluations, Dr. Galt wrote on December 3, 1992, that he had reviewed the PCE results and that he disagreed with the restriction they recommended for certain positional activities. He then wrote: "Otherwise, I agree with the Physical Capacities Evaluation." However, Dr. Galt later went on to write: "If impairment is desired, I would recommend an independent evaluation for the impairment rating." (Ex. 27).

While Dr. Galt's express agreement with the PCE could be interpreted as a concurrence with its impairment findings, we conclude that his subsequent recommendation for an independent evaluation "[i]f impairment is desired" is inconsistent with that interpretation. Read as whole, we interpret Dr. Galt's December 3, 1992 report as a concurrence with only the PCE findings regarding claimant's residual physical capacities, not the impairment findings.

Subsequently, by a "check-the-box" response dated January 2, 1993, Dr. Galt expressly agreed with the findings in the December 2, 1992 report by Drs. McKillop and Rich. He expressed no reservation concerning that report. (Ex. 29). Therefore, we find that Dr. Galt concurred with the finding by Drs. McKillop and Rich that claimant has no permanent impairment.

Accordingly, based on Dr. Galt's January 2, 1993 concurrence, we conclude that claimant has not proved that she sustained any permanent impairment due to the compensable injury. We reverse the Referee's permanent disability award.

ORDER

The Referee's order dated August 30, 1993 is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety.

April 5, 1994 Cite as 46 Van Natta 692 (1994)

In the Matter of the Compensation of
THOMAS E. JOHNSTON, Claimant
WCB Case Nos. 92-06869, 92-06868, 91-15014, 92-03321 & 92-09254
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys
John Motley (Saif), Defense Attorney

Claimant requests reconsideration of our March 7, 1994 order which upheld denials of claimant's neck condition issued by the SAIF Corporation, on behalf of Mt. Mazama Plywood, and Liberty Northwest Insurance Corporation, on behalf of Emerald Forest Products. Contending that we misinterpreted some of the medical opinions, claimant asks that we reexamine the compensability and responsibility issues regarding his neck condition.

In order to consider claimant's motion for reconsideration, we withdraw our March 7, 1994 order. The insurers are granted an opportunity to respond. To be considered, each insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARLA G. PAVLICEK, Claimant
WCB Case No. 92-12869
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Lipton's order which: (1) upheld the insurer's denial of claimant's occupational disease claim for her right knee condition; and (2) declined to assess a penalty for failure to provide discovery. On review, the issues are compensability and discovery.

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

Claimant had right knee surgery in 1976 with subsequent degeneration. She had no problems with her knee until after July 1990 when she began to work for the self-insured employer, even though she had participated in skiing, hiking and other strenuous off-work activities since her 1976 surgery.

In August 1992, claimant saw Dr. Grewe for right knee pain and swelling. Dr. Grewe diagnosed a residual medial meniscus tear. (Ex. 4). On November 27, 1992, Dr. Grewe performed a right knee arthroscopy with medial meniscectomy. Claimant filed an occupational disease claim for her right knee condition.

Claimant argues that she has a "predisposition" rather than a preexisting condition. Claimant bases her argument on a statement from Dr. Grewe's report that claimant "had a pre-existing condition in her knee that predisposed her to developing an effusion, pain and inflammation * * * ." (Ex. 12-1). We do not agree, however, that claimant's prior knee condition is properly analyzed as a predisposition to her current knee condition.

A predisposition is a condition of special susceptibility to a disease, not a disease in itself. See Rodney T. Buckallew, 44 Van Natta 358, 360 (1992), aff'd Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993). Here, considering Dr. Grewe's opinion as a whole, particularly his current diagnosis of degenerative knee changes caused by claimant's preexisting knee surgery, we conclude that the degenerative changes in claimant's right knee comprised the disease that "predisposed" claimant to develop symptomatic effusion and pain. (See Ex. 12).

Accordingly, in order to prove a compensable occupational disease, claimant has the burden of proving that her employment conditions were the major contributing cause of a worsening of her preexisting knee condition. ORS 656.802(2). Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. Weller v. Union Carbide, 288 Or 27 (1979).

Dr. Grewe stated that the main cause of claimant's knee problems was her previous injury and degenerative changes, and that increased work activity caused a symptomatic increase in pain and inflammation of the knee. (Ex. 12-1). Dr. Grewe further stated that he performed arthroscopy to clarify his diagnosis and treat claimant's symptoms. (Ex. 12-1). The pathology, however, was related to claimant's preexisting condition. Id.

At best, claimant has suffered a symptomatic worsening of a preexisting condition. However, she must prove a pathological worsening in order to establish a compensable occupational disease. Weller, supra. In light of the medical evidence, we are persuaded that claimant has failed to prove that she has a compensable occupational disease.

Claimant next argues that she is entitled to a penalty for failure of the claims processor to produce certain documents that were in the possession of the claims processor. Here, however, even if the record established the occurrence of a discovery violation, the underlying claim is not compensable. Thus, there has been no unreasonable resistance to the payment of compensation. Under such circumstances, claimant is not entitled to a penalty pursuant to ORS 656.262(10). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated March 16, 1993 is affirmed.

In the Matter of the Compensation of
GARY WILLIAMS, Claimant
WCB Case No. 92-15324
ORDER ON REVIEW
Susan J. Lax, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Nichols' order that declined to assess a penalty for the insurer's allegedly unreasonable denial of his occupational disease claim for a right shoulder condition. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Although the Referee set aside the insurer's denial on the merits, she concluded that its denial was not unreasonable and, therefore, did not justify assessment of a penalty. On review, claimant contends that the Referee erred, because the insurer did not have a legitimate doubt about its liability for his claim. We agree.

ORS 656.262(10)(a) provides that a carrier shall be assessed a penalty if the carrier unreasonably refuses to pay compensation. A carrier's denial of a claim is unreasonable if the carrier did not have a legitimate doubt about its liability for the claim. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). The unreasonableness of a denial is determined in the light of all the evidence available to the carrier at the time of its denial. Id.

Here, the insurer issued its denial on October 9, 1992. (Ex. 121). Therefore, we review all the evidence available to the insurer prior to that date in order to determine whether the insurer had a legitimate doubt about its liability.

According to claimant's uncontroverted testimony, claimant told the assistant manager on July 14, 1992 that he was experiencing shoulder pain after lifting tires at work. (Tr. 16). Claimant further testified that, when the pain worsened, he was told to see Dr. Schroff. (Tr. 16).

That same day, claimant saw Dr. Schroff with complaints of left shoulder pain. Claimant reported that the pain was caused by lifting at work. Dr. Schroff found tenderness upon palpation in the shoulder area, diagnosed a probable overuse strain and prescribed pain medication. (Ex. 108). Claimant was also given a written release for modified work. (Ex. 107).

A few days later, claimant filed with the employer an 801 claim form alleging a work-related shoulder strain. (Ex. 106). In addition, Dr. Schroff filed with the employer, on claimant's behalf, an 827 claim form indicating that claimant sustained a shoulder strain due to repetitive lifting at work. (Ex. 109).

After claimant's subsequent office visits in late July 1992, Dr. Schroff expressed doubts about claimant's motivation to return to work and recommended an orthopedic consultation for a "more objective evaluation." (Ex. 110). Claimant was subsequently seen by orthopedist Dr. Neumann, who reported tenderness in the shoulder area and prescribed pain medication. Dr. Neumann also discussed the possibility of treating claimant with injections and physical therapy. (Ex. 116).

Based on the above evidence, all of which the insurer received prior to issuing its denial, we do not find that the insurer had a legitimate doubt about its liability for the shoulder claim. All of the medical evidence indicated that claimant sustained a shoulder condition as a result of work activities for the employer.

Moreover, contrary to the insurer's contention, we find that the existence of the shoulder condition was established by medical evidence supported by objective findings. We base our finding on: (1) the medical findings of tenderness in the shoulder area; (2) Dr. Schroff's diagnosis of an overuse strain; (3) the prescriptions for medication; and (3) Dr. Schroff's modified work release. Based on their objective evaluations of claimant's complaints, Drs. Schroff and Neumann concluded that claimant suffers from a shoulder condition. That is sufficient to prove "objective findings." See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471, 475 (1992); Todd N. Hellman, 44 Van Natta 1082 (1992).

The insurer argues that it had a legitimate doubt about the claim because of claimant's "attitude problem" and previous confrontations with his supervisor. We disagree. While such evidence is relevant in determining the compensability of a claim, we do not find that evidence sufficient to establish legitimate doubt in the face of the aforementioned evidence supporting the claim. Accordingly, we conclude that the insurer's denial was unreasonable, and assess a penalty.

ORDER

The Referee's order dated July 15, 1993 is reversed in part and affirmed in part. That portion of the order that declined to assess a penalty against the insurer is reversed. The insurer 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 setting aside the denial. The penalty shall be paid in equal shares to claimant and his counsel. The remainder of the order is affirmed.

April 6, 1994 Cite as 46 Van Natta 695 (1994)

In the Matter of the Compensation of
DIANE L. HOYT, Claimant
WCB Case No. 91-09229
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

The parties requested clarification of our March 11, 1994 Order on Review that reversed Referee Davis' order that set aside the August 26, 1991 Determination Order and the March 6, 1992 Order on Reconsideration as premature. Specifically, the parties ask for clarification regarding whether our order affirmed a 15 percent unscheduled permanent partial disability award, or reduced the award to 5 percent.

We withdraw our March 11, 1994 order, and offer the following clarification.

The March 6, 1992 Order on Reconsideration found that claimant had a 5 percent impairment rating for her right shoulder. (See Ex. 65-4). See OAR 436-35-007; OAR 436-35-320. On the basis of that impairment value, the order awarded claimant a 15 percent unscheduled permanent partial disability. (Ex. 65). Concluding that claimant had failed to establish an impairment rating of more than 5 percent, our March 11, 1994 order reinstated and affirmed the Order on Reconsideration.

On reconsideration, we adhere to that conclusion, and affirm the Order on Reconsideration's 5 percent impairment value for claimant's right shoulder, as well as the ultimate award of 15 percent unscheduled permanent partial disability. In other words, our specific reference to claimant's 5 percent impairment rating pertained to the impairment value awarded with respect to claimant's right shoulder, not to the entire award of 15 percent unscheduled permanent partial disability.

Accordingly, on reconsideration, as supplemented herein, we republish our March 11, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK S. LILLIBRIDGE, Claimant
WCB Case No. 93-01844
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Claimant requests reconsideration of our March 10, 1994 Order on Review that reduced claimant's unscheduled permanent disability award from 23 percent, as granted by the Referee, to 15 percent. Claimant asserts that England v. Thunderbird, 315 Or 633 (1993), invalidated the administrative rule (OAR 436-35-310(2), WCD Admin. Order 6-1992) by which we calculated claimant's adaptability factor.

We withdraw our March 10, 1994 order. On reconsideration, we continue to adhere to the reasoning and conclusions reached in our original order. See Michelle Cadigan, 46 Van Natta 307 (1994). Consequently, we republish our March 10, 1994 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
SANDIE K. DRIVER, Claimant
WCB Case No. 90-12482
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Driver v. Rod & Reel Restaurant, 125 Or App 661 (1994). The court reversed our prior order, Sandie K. Driver, 44 Van Natta 416 (1992), which reduced claimant's scheduled permanent disability award because the findings supporting claimant's disability had been rendered by a physical therapist. Concluding that a physical therapist satisfies the definition of "physician" in ORS 656.005(12), 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 scheduled permanent disability in part based on his finding that claimant had proved loss of grip strength based on a physical therapist's report. The Board disagreed and reduced claimant's scheduled permanent disability award, reasoning that no "physician" had measured claimant's grip strength nor had any "physician" adopted the physical therapist's findings. Sandie K. Driver, supra.

The Court of Appeals reversed. Driver v. Rod & Reel Restaurant, supra. Citing ORS 656.005(12)(a) (which defines "physician") and former OAR 436-35-005(1) (which requires impairment to be measured by a "physician"), the court identified the question as whether physical therapy is one of the "healing arts." Relying on the Supreme Court's definition of "healing arts" provided in Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988), and ORS 688.010 (which defines "physical therapy"), the court concluded that physical therapists practice a "healing art" in that they treat a patient's physical disability and, where the nature of the problem permits, restore the patient to health.

Consequently, the court held that the Board had erred in concluding that a physical therapist did not satisfy the definition of "physician" in ORS 656.005(12). Unable to discern whether the Board would have reached the same result but for its erroneous "physical therapist" conclusion, the court remanded for reconsideration. In reaching its decision, the court noted that neither the Board nor the parties on appeal had addressed whether the "attending physician impairment findings" provisions of ORS 656.245(3)(b)(B) were applicable to the dispute. Driver v. Rod & Reel Restaurant, supra.

In accordance with the court's mandate, we now proceed with our reconsideration. The Referee awarded scheduled permanent disability based in part on his finding that claimant proved loss of grip strength. In making this determination, the Referee apparently relied on the physical therapist's findings that claimant demonstrated less grip strength in her injured right arm in comparison to her uninjured left arm.

Under the applicable standards, loss of grip strength was ratable only if such loss is attributable to nerve damage, atrophy, or other anatomical changes due to the compensable condition. Former OAR 436-35-110(3) (WCD Admin. Order 6-1988). Although the physical therapist found that claimant's grip strength was less on the right in comparison to the left, there is no explanation concerning the cause of the finding and no indication that any loss of grip strength was the result of nerve damage, atrophy, or other anatomical changes due to the compensable condition. (Ex. 31). Therefore, even if the physical therapist's findings could be considered for purposes of evaluating claimant's permanent impairment, we conclude that the physical therapist's findings do not satisfy the standards for loss of grip strength.

Alternatively, the physical therapist's findings regarding claimant's grip strength are not relevant to determining her impairment.[1] With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, impairment findings from a physician, other than the attending physician, may be used if those findings are ratified by the attending physician. Donald R. Strom, 46 Van Natta 158 (1994); Alex J. Como, 44 Van Natta 221 (1992). Therefore, although qualifying as a physician, findings by a physical therapist are not relevant to claimant's impairment unless adopted by the attending physician or unless the physical therapist was claimant's attending physician.

The Referee found that, on January 3, 1990, Dr. Sullivan became claimant's attending physician. That finding has not been disputed by the parties and we have adopted it in this order. Therefore, the physical therapist was not claimant's attending physician at the time the physical therapist evaluated claimant on October 3, 1990. Furthermore, there is no evidence that Dr. Sullivan adopted or ratified the physical therapist's findings. Consequently, we find that the physical therapist's findings are not relevant to determining claimant's impairment.

Thus, having found that claimant failed to prove entitlement to impairment based on loss of grip strength, we continue to conclude that claimant is entitled only to 3 percent scheduled permanent disability. Accordingly, on reconsideration, as supplemented and modified herein, we republish our March 10, 1992 order.

IT IS SO ORDERED.

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[1] Inasmuch as claimant requested a hearing from the Notice of Closure on June 12, 1990 and the hearing convened on October 9, 1990, the 1990 amendments, including ORS 656.245(3)(b)(B), were applicable to this proceeding. See Or Laws 1990 (Special Session), ch 2, section 54.

We recognize that the parties have not addressed the effect of ORS 656.245(3)(b)(B) on the extent of claimant's permanent disability. Nevertheless, we are obligated to follow the law in effect at the time of the hearing. In view of the applicability of ORS 656.245(3)(b)(B), we evaluate the medical evidence in view of the statute's requirements.

In the Matter of the Compensation of
DARIN L. JONES, Claimant
WCB Case Nos. 89-08355 & 89-10618
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Hall.

The SAIF Corporation requests review of that portion of Referee Black's order that set aside an Order on Reconsideration finding claimant medically stationary on January 24, 1991. In the event the Board finds the claim was not prematurely closed, SAIF requests that the Determination Order award of 10 percent (32 degrees) unscheduled permanent disability (PPD) be affirmed. In his brief, claimant requests that, should the Board find that his claim was not prematurely closed, the case be remanded for determination concerning extent of unscheduled PPD. On review, the issues are premature closure, extent of unscheduled disability, and remand. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

As a threshold matter, we acknowledge that subsequent to the filing of Board briefs in this case, claimant submitted a document captioned "Supplemental Reply Brief," purporting to contain "Additional Points and Authorities." Any party may provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. Here, the case to which claimant cites was in existence at the time of briefing, as evidenced by the fact that SAIF cited the case in its Appellant's brief. Moreover, unless otherwise authorized by the Board, further argument will not be considered. OAR 438-11-020(2); Betty L. Juneau, 38 Van Natta 553 (1986). Accordingly, we do not consider claimant's submission in our review.

Premature Claim Closure

We agree with the Referee that SAIF's notice to claimant was inadequate to allow claim closure based on a presumption that claimant was medically stationary. We do so, however, based on the following reasoning.

Former OAR 436-30-035(7) (WCD Admin. Order 33-1990) provides, in relevant part, that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, provided that the insurer has notified the worker that claim closure would occur due to the worker's failure to seek medical treatment.

Subsequent to the Referee's decision, in Bertha Paniagua, 46 Van Natta 55 (1994), we concluded that, to be entitled to claim closure based on a presumption that the claimant is medically stationary, the notice given by the insurer must be in strict compliance with OAR 436-30-035. In reaching this conclusion, we reasoned that the purpose of this rule is not to penalize the worker for failing to see his or her doctor. Rather, where the worker fails to treat with his doctor after having received specific notice that his claim will be closed for that failure, the rule appropriately allows the claim to be closed based on a presumption that if the worker needed medical treatment, he would have sought medical treatment. However, "the notice given must clearly and plainly state that the claim will be closed if claimant fails to return to [his] doctor for treatment." Paniagua, supra.

Here, the notice given by SAIF was inadequate to trigger application of the presumption. SAIF briefly discussed claim closure in one paragraph of a lengthy letter which primarily concerned certain obligations of claimant's new attending Alaskan physician under Oregon workers' compensation law. We agree with the Referee that the notice given by SAIF was inadequate to allow claim closure under the rule.

Alternatively, we also conclude that the record is inadequate to justify claim closure based on the medical evidence. First, we note that SAIF has never contended that claimant should or can be

found medically stationary based on the medical evidence. Instead, SAIF sought and obtained closure under former OAR 436-30-035 based upon a presumption to which it was not entitled. Moreover, claimant's claim cannot be closed based on this record where the last report from the treating physician prior to closure specifically opined that claimant was not yet medically stationary.

Remand/Unscheduled Permanent Disability

Given our conclusion that the notice given by SAIF was inadequate to allow claim closure based on a presumption that claimant was medically stationary, we do not reach the issues of remand or extent of unscheduled permanent disability.

Claimant's attorney is entitled to an assessed attorney 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 $800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated December 16, 1992 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $800, to be paid by the SAIF Corporation.

Board Member Hall specially concurring.

I agree that SAIF's notice to claimant was not adequate to allow claim closure based on a presumption that claimant was medically stationary. OAR 436-30-035(7). I write separately, however, to express my concerns regarding OAR 436-30-035(8).

Former OAR 436-30-035(7) (WCD Admin. Order 33-1990) provides, in relevant part, that a worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, provided that the insurer has notified the worker that claim closure could occur due to the worker's failure to seek medical treatment. Former OAR 436-30-035(8) further provides, in relevant part, that the worker is presumed to be medically stationary 10 days from the expected date of response to an insurer's notification letter, unless subsequent medical evidence, based on actual examination of the worker, establishes that the worker was not medically stationary on that date. Absent an actual physical examination, the worker is prohibited from overcoming the "presumption."

I believe the latter requirement (an actual examination of the claimant) is contrary to the controlling statute. ORS 656.268. OAR 436-30-035(8) improperly limits the challenge to the medically stationary date in a "presumptive" closure and requires a claimant to meet a different evidentiary standard (medical evidence based on actual examination) than the standard applicable to a claimant challenging the medically stationary date in a non-presumptive closure.

Generally, in order to establish that a Notice of Closure or Determination Order was issued prematurely or that the medically stationary date was not correct, a claimant need only establish the error by a preponderance of the evidence in the record as a whole. See Berliner v. Weyerhauser Corp., 54 Or App 624 (1981); Timothy H. Krushwitz, 45 Van Natta 158 (1993). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). This is fundamentally a medical question, consistently treated as such by this Board and the appellate courts. See, e.g., Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980) (the question of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence, including circumstantial medical evidence). Neither the statute nor case law requires the medical evidence to take a specific form.

Silence has never been sufficient to establish a claimant's medically stationary status. I would find, therefore, that OAR 436-30-035(8) places constraints on a claimant's appeal of a Determination Order which are not authorized by statute and contrary to recent case law. ORS 656.268; see Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) (there is no limitation on evidence that can come in at hearing on appeal of a Determination Order). Just because a claim can be "presumptively" closed does not mean a claimant may be limited in the appeal of that Determination Order.

The instant case highlights the problem with the rule. Were we to apply OAR 436-30-035(8) and require medical evidence based on an actual subsequent examination, we would have to ignore Dr. Kendrick's October 1991 report unequivocally establishing that claimant was not yet medically stationary when last examined. OAR 436-30-035(8) should be invalidated to the extent it exceeds statutory authority. Challenges to a presumed stationary date should be the same as that to non-presumptive claim closures.

In the Matter of the Compensation of
MICHELLE KOPCHAK, Claimant
WCB Case No. 91-06147
ORDER ON REMAND (REMANDING TO DIRECTOR'S APPELLATE UNIT)
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Kopchak v. Eugene Ballet Company, 126 Or App 268 (1994). The court has reversed our prior order, which held that the Board was without authority to remand an Order on Reconsideration to the Director for the adoption of a temporary rule regarding the disability standards (ORS 656.726(3)(f)(C)). Citing Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

In September 1988, claimant sustained a compensable right knee injury. Her condition was diagnosed as a right patellar tendon strain. Her claim was first closed by a March 31, 1989 Determination Order which awarded temporary disability benefits only. Her claim was subsequently reopened and then again closed by a September 20, 1990 Determination Order. Again, claimant was awarded only temporary disability benefits.

Claimant requested reconsideration of the September 20, 1990 Determination Order. At reconsideration, claimant contended she was entitled to an award of permanent disability for chondromalacia in her right knee as a result of the compensable injury. Claimant's contention was based on Dr. Graham's report which indicated that claimant had sustained permanent impairment in the form of chondromalacia in her right knee. (Ex. 16). Without expressly finding that the existing standards adequately addressed claimant's disability, the Director issued an Order on Reconsideration affirming the Determination Order. Thereafter, claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Order on Reconsideration. On review of the Referee's order, we affirmed. Citing Gary D. Gallino, 43 Van Natta 2506 (1992), we determined that we were without authority to consider whether the Director had correctly applied the existing standards to address claimant's disability. In addition, we held that we were not authorized to remand to the Director for promulgation of a temporary rule.

Relying on ORS 656.726(3)(f)(C), the Gallino court reasoned that the Director was required to stay further proceedings and adopt temporary rules "upon a finding that a disability is not addressed by existing standards." Since the Board is authorized under ORS 656.295(5) to review the correctness of the Director's application of the standards, the Gallino court concluded that the Board has the power to review the Director's application of existing standards to address chondromalacia. Furthermore, because only the Director can grant the relief requested by the claimant (the promulgation of a temporary rule), the Gallino court held that, by necessary implication, the Board is empowered to remand the case to the Director and must do so.

Citing Gallino, the court has reversed and remanded our prior decision. Consequently, we proceed with our reconsideration.

Here, claimant requested reconsideration of the Determination Order contending that her disability had been improperly rated. Specifically, claimant contended that she was entitled to an award for chondromalacia in her right knee. Claimant's request was supported by Dr. Graham's report which indicated that claimant had sustained permanent impairment in the form of chondromalacia in her right knee. (Ex. 16).

Without expressly finding that the existing standards adequately addressed claimant's disability, the Director issued an Order on Reconsideration affirming a Determination Order which did not award any permanent disability.

We are compelled to remand to the Director upon a finding that, at the time of the issuance of an Order on Reconsideration, a disability was not addressed by the existing standards and the Director neglected to stay further proceedings and adopt a temporary rule. See ORS 656.726(3)(f)(C); Gary D. Gallino, on remand, 46 Van Natta 246 (1994).

Under these circumstances, we conclude that the Director was required to stay the reconsideration proceedings and promulgate a temporary rule regarding claimant's disability. Id. Likewise, since we are not authorized to adopt such a rule, we are required to remand to the Director for promulgation of that rule.

In reaching this conclusion, we acknowledge that the Director has subsequently adopted a permanent rule addressing chondromalacia. See OAR 436-35-230(13). Moreover, we recognize that we are authorized to apply such a rule on review. See OAR 438-10-010; 436-35-003(2). Nevertheless, as we reasoned in our remand order in Gallino, we are compelled to remand to the Director upon a finding that, at the time of issuance of an Order on Reconsideration, a disability was not addressed by existing standards and the Director neglected to stay further proceedings and adopt temporary rules. See ORS 656.726(3)(f)(C); Gallino v. Courtesy Pontiac-Buick-GMC, supra. Furthermore, again as we reasoned in Gallino, the Director's subsequent adoption of a permanent rule concerning chondromalacia does not necessarily foreclose the Director from finding that this "worker's disability is not addressed by the [existing] standards." See e.g. WCD Admin. Order 93-054.

Therefore, we vacate the Referee's order dated June 19, 1992. In accordance with the Gallino decision, we remand this case to the Director for further proceedings consistent with this order.

IT IS SO ORDERED.

April 8, 1994 Cite as 46 Van Natta 701 (1994)

In the Matter of the Compensation of
JEAN K. MOMAN, Claimant
WCB Case No. 92-16292
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The Board has received claimant's request for reconsideration of the Board March 24, 1994 Order on Review.

We have abated our March 3, 1994 order regarding the underlying compensability issue, which we relied upon in determining the issues of premature claim closure and extent of disability in our March 24, 1994 order. Therefore, in order to allow sufficient time to consider the motion, we abate and withdraw our March 24, 1992 order. The self-insured employer is requested to file a response to the motion within 14 days from the date of this order. Thereafter, the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD J. NIES, JR., Claimant
WCB Case No. 92-12010
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a psychological condition; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are aggravation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

In lieu of the third and the second to last paragraphs on page 2 of the Opinion and Order, we find the following.

On September 6, 1986, claimant sustained a work-related injury to his left hand and elbow. (Ex. 15). The insurer initially denied a left elbow condition (Ex. 19), but then accepted a left arm condition pursuant to a stipulated order. (Ex. 32). Dr. Neitling, claimant's treating orthopedic surgeon, performed left elbow surgery on November 20, 1987. (Exs. 39-42). Claimant continued to have pain.

In early 1988, Dr. Neitling referred claimant to Dr. Fleming, psychologist, for evaluation and treatment of claimant's ongoing problems relating to his left arm. Dr. Fleming examined claimant in April 1988 and began psychological counselling. Dr. Fleming diagnosed Adjustment Disorder with Depression.

The insurer's denial of claimant's psychological condition claim was set aside by an order dated November 8, 1989.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion", with the following modification.[1]

In lieu of the second to the last paragraph on page 8 of the Opinion and Order, we offer the following analysis.

In July 1992, claimant told Dr. Maletzky that his overall condition was improving. (Ex. 215B-1). Nevertheless, on December 15, 1992, Dr. Maletzky concluded, without explanation, that claimant's mental condition had become worse in late spring and summmer 1992. (Ex. 221). In November 1992, Dr. Maletzky again examined claimant; in March 1993, Dr. Maletzky confirmed that there had been no change between the July 1992 and November 1992 examinations. (Ex. 223).

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[1] In adopting the Referee's conclusions, we note that the Referee used the "last opportunity to present evidence" rule to determine that claimant must show his condition worsened after the issuance of the Determination Order. Subsequent to the Referee's order, we held that, in the aggravation context, the "base line" for determining whether the compensable condition has worsened is the evidence describing the claimant's "medically stationary" condition at or before the last award or arrangement of compensation; that is, the last time the claimant was medically and legally determined to be medically stationary. Lindon E. Lewis, 46 Van Natta 237, 239 (1994). Because claimant was last medically and legally determined to be medically stationary by the Determination Order, under Lewis, the Referee's conclusion regarding the worsening "base line" in this case remains correct.

In light of claimant's report to Dr. Maletzky in July 1992 that his condition actually was improving, and Dr. Maletzky's March 1993 report that claimant's condition had been unchanged between July and November 1992, we conclude that Dr. Maletzky's conclusion that claimant's condition had worsened in spring and summer 1992 is illogical. Accordingly, it is entitled to minimal probative weight. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, we find that the inconsistent reports that claimant gave Drs. Maletzky and Fleming regarding the efficacy of Prozac therapy undermines the validity of Dr. Maletzky's (as well as Dr. Fleming's) reports. See id. Lastly, we discount Dr. Maletzky's reports because he did not provide a meaningful comparison between claimant's condition at the time the Determination Order issued and claimant's condition thereafter. See McDonald v. Roseburg Forest Products, 114 Or App 486 (1992). For these reasons, we conclude that Dr. Maletzky's opinions are not persuasive evidence of a worsening of claimant's compensable psychological condition.

ORDER

The Referee's order dated June 16, 1993 is affirmed.

In the Matter of the Compensation of
LORNA I. YOUNG, Claimant
WCB Case Nos. 93-06731 & 93-05977
INTERIM ORDER OF DISMISSAL
Nancy F.A. Chapman, Claimant Attorney
Mitchell, et al., Defense Attorneys
Thomas Castle (Saif), Defense Attorney

The SAIF Corporation has requested review of Referee Menashe's order that: (1) set aside SAIF's denial of claimant's "new injury" claim for a low back condition; (2) upheld USF & G's denial of claimant's aggravation claim for the same condition; and (3) assessed SAIF penalties for allegedly unreasonable claim processing. Claimant and USF & G have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them in this matter. Pursuant to the settlement, claimant agrees that USF & G's denials "are affirmed." The agreement further provides that claimant's dispute with USF & G shall be dismissed with prejudice.

We have approved the settlement, thereby fully and finally resolving the dispute between claimant and USF & G. Consequently, those issues will not be further addressed on review. In approving this settlement, we wish to emphasize that claimant is accepting the possibility that she will not receive compensation from the remaining carrier (SAIF). See E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Linda J. Smith, 44 Van Natta 2361 (1992); Jack Spinks, 43 Van Natta 1181, 43 Van Natta 1350 (1991), aff'd mem Spinks v. Mosley and Sons, 112 Or App 661 (1992).

Finally, since SAIF's request for Board review remains pending, we retain jurisdiction over this case. In other words, we shall proceed with our review of the issues raised by SAIF's appeal. Accordingly, this order shall be interim and shall be incorporated into our final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILLIE I. ENSLEY, Claimant
WCB Case No. 93-03765
ORDER OF ABATEMENT
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

The insurer requests reconsideration of our March 11, 1994 Order on Review which adopted and affirmed the Referee's order finding claimant's current neck condition compensable as a consequential condition under ORS 656.005(7)(a)(A). Specifically, the insurer contends that claimant's neck condition, caused by the physical therapy regimen prescribed for her compensable low back condition, is not compensable unless claimant establishes that the compensable injury itself was the major contributing cause of the neck condition. The insurer contends that we erred in holding the claim compensable based on a finding that the physical therapy regimen was the major contributing cause of the neck condition.

In order to allow us sufficient time to consider the insurer's motion, we withdraw our March 11, 1994 order. Claimant may submit a response to the motion. To be considered, claimant's response should be submitted within 14 days from the date of this order. Thereafter, we shall proceed with our review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNAL M. DAVIDSON, Claimant
WCB Case Nos. 93-02875 & 93-02863
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of that portion of Referee Thye's order which affirmed an Order on Reconsideration assessing a penalty under ORS 656.268(4)(g), based on an increase in claimant's scheduled permanent disability award for the loss of use or function of the left knee from 14 percent (21 degrees), as awarded by a Notice of Closure, to 23 percent (34.5 degrees). On review, the issue is penalties.

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

First, SAIF urges us to reconsider our decision in Kevin Northcut, 45 Van Natta 173 (1993), in which we held that a claimant is automatically entitled to a penalty under ORS 656.268(4)(g) when the statutory requirements are met. We decline to do so.

Next, SAIF contends that a penalty is improper in this case because it is contrary to the Director's rule, OAR 436-35-050(13). That rule proves that, for purposes of assessing a penalty under ORS 656.268(4)(g), "a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled."

Here, on reconsideration, the Appellate Unit assessed a penalty under ORS 656.268(4)(g) because it found that claimant was at least 20 percent disabled, based on its award of 23 percent (34.5 degrees) scheduled permanent disability. (Exs. 47, 48).

ORS 656.268(4)(g) provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

This statutory provision authorizes assessment of a penalty against an insurer or self-insured employer if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. If the statutory requirements are met, the claimant is automatically entitled to the penalty, without regard to whether the carrier's action was reasonable. Kevin Northcut, supra.

Here, we agree with the Appellate Unit's determination that both conditions were satisfied. The Appellate Unit's interpretation is consistent with the unambiguous language of ORS 656.268(4)(g), which expressly applies to claimants who are found to be "at least 20 percent permanently disabled." Claimant was awarded more than 20 percent scheduled disability for his left leg. We conclude that claimant has satisfied the statutory minimum of "20 percent" permanent disability.

An agency may not "alter, amend, enlarge or limit the terms of an applicable statute by rule." Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992) (citing Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988)). Here, we have found that the Appellate Unit's interpretation is consistent with the terms of the statute. Accordingly, we reject SAIF's argument and decline to interpret OAR 436-35-050(13) as a bar to the assessment of a penalty pursuant to the terms of ORS 656.268(4)(g). See Steven L. Cline, 46 Van Natta 132 (1994), on recon 46 Van Natta 512, n.1 (1994).

ORDER

The Referee's order dated August 27, 1993 is affirmed.

April 11, 1994 Cite as 46 Van Natta 705 (1994)

In the Matter of the Compensation of
JACKIE DUPELL, Claimant
WCB Case No. 93-04215
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee McCullough's order that set aside its denial of claimant's claim for a left shoulder, neck and right ankle injury. On review, the issue is compensability.

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

At the hearing, the parties agreed that the only issue regarding the compensability of claimant's claim was whether her injury on March 16, 1993 arose out of the course and scope of her employment.

On review, the insurer agrees that claimant's fall caused her injuries, but contends that the cause of the fall presents a complex medical question requiring expert medical evidence. In Ruben G. Rothe, 45 Van Natta 369, 372 (1993), we held that ORS 656.266 requires a claimant to affirmatively prove that his or her condition was, in fact, related to the work environment. Here, the medical evidence establishes, and the parties have stipulated, that the fall caused claimant's injury. The only issue is the relationship of the fall to claimant's work environment.

The record does not support the insurer's contention that the cause of claimant's fall presents a complex medical question. Based upon claimant's testimony, which the Referee found credible, and the testimony of her co-workers, the Referee found that claimant fell because she stepped on something on the floor of the employer's premises and twisted her ankle. There was evidence that small parts often fell on the floor at the employer's premises. In addition, there was evidence that such objects were difficult to see because of the pattern of the flooring. Moreover, the record contains no evidence that claimant's fall was related to idiopathic factors or that claimant had any condition or impairment that might have caused her to fall. As the Referee noted, claimant had strained her right ankle in February 1992 and was treated in an emergency room for that injury, but had received no further treatment. The record contains no persuasive evidence that claimant had any right leg or ankle problems prior to the March 16, 1993 injury.

In the absence of any evidence that claimant's injury was related to idiopathic factors, or to any physical infirmity that claimant had, we conclude that the cause of claimant's fall did not present a complex medical question. The record establishes, and we are convinced, that claimant's fall was caused by an object on the floor at the employer's premises. Accordingly, we conclude that claimant has established that her injuries were related to her work environment. Ruben G. Rothe, supra.

The insurer also contends that claimant is not credible. The Referee found claimant credible based upon her demeanor while testifying. We generally defer to the Referee's determination of credibility when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). Here, after reviewing the record, we find no basis not to defer to the Referee's demeanor-based credibility finding.

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

ORDER

The Referee's order dated August 6, 1993 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
MAURICE L. McCREIGHT, Claimant
WCB Case No. 91-17664
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Holtan's order that set aside its denial of claimant's occupational disease claim for angina, hypertension and coronary artery disease. On review, the issue is compensability.

We adopt and affirm the Referee's order with the exception of the last paragraph on page 7. We supplement the Referee's order as follows.

The Referee found that claimant satisfied the requirements of the fire fighter's presumption, and concluded that the employer had failed to overcome the presumption by clear and convincing medical evidence.

In its appellant's brief, the employer concedes that this case falls within the fire fighter's presumption contained in ORS 656.802(4). The narrow issue on review is whether or not the employer has rebutted the presumption by presenting clear and convincing evidence that the cause of claimant's condition is unrelated to his employment as a fire fighter. The employer contends that the Referee applied the incorrect legal standard because he stated that the very existence of a split in the medical record before him was sufficient to prevent the employer from proving its case against the fire fighter's presumption by clear and convincing evidence.

To be clear and convincing, the evidence must be free from confusion, fully intelligible, and distinct. To be both clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). The fire fighter's presumption is a disputable presumption. When the facts giving rise to the presumption are established, the presumption is binding if there is no opposing evidence. Wright v. SAIF, 289 Or 323 (1980). If there is opposing evidence, the trier of fact must weigh the evidence, giving the presumption the value of evidence, and determine upon which side the evidence preponderates. Id at 331.

We agree with the employer that the mere existence of divergent medical opinion favoring claimant's case does not necessarily prevent the employer from meeting its burden to overcome the presumption by clear and convincing medical evidence. We also agree with the employer that the factfinder must weigh the evidence and determine whether the clear and convincing standard has been met. To the extent that the Referee's statements in the last paragraph on page 7 of his order can be interpreted as suggesting otherwise, we do not adopt that portion of his order.

However, we do agree with the Referee's conclusion and reasoning that the employer has not overcome the presumption by clear and convincing evidence. We also conclude that the Referee did not apply an incorrect legal standard, but properly weighed the evidence and concluded that the clear and convincing standard had not been met. The Referee reasoned:

> "The presumption itself is, of course, based in the legislature's public policy decision to afford fire fighter's additional protection in the workers' compensation arena. In the absence of expert medical opinion supporting compensability, the presumption would not defeat the high quality opinions of the three cardiologists in this record. This evidentiary record, however, does contain credible medical evidence in claimant's favor. The presumption remains as evidence, simply adding to the claimant's case."

Three cardiologists, Drs. Frierson, Shepherd, and Rogers, believe that claimant's condition is not related to his employment as a fire fighter. On the other hand, three other physicians, McCarron, a specialist in hypertension, and Thomas and Morton, support claimant's contention that his condition is related to his employment. The employer contends that claimant's medical experts are unpersuasive and that, consequently, it has established that it is highly probable that claimant's angina, hypertension and coronary artery disease are unrelated to his employment.

Although the Referee accorded Dr. Thomas' opinion on causation less probative weight since he is not a specialist and found Dr. Morton less persuasive than Dr. Shepherd, he found Dr. McCarron's opinion persuasive. Dr. McCarron is a specialist in hypertension with impressive credentials. He has authored numerous articles on hypertension, and his research and knowledge of the medical literature have led him to conclude that intermittent exposure to severe stress can produce hypertension. He has opined that the combination of claimant's hypertension and job stress is sufficient to account for the lesion identified in claimant's case. Dr. McCarron's persuasive opinion, in conjunction with the opinions of Drs. Thomas and Morton, persuade us that this record is not free from confusion, fully intelligible, and distinct. Moreover, we note that the presumption itself is entitled to some evidentiary weight.

Thus, after weighing the evidence, we are unable to conclude that it is "highly probable" that claimant's condition did not result from his employment. Accordingly, based upon this record, we agree with the Referee that the employer has not established by clear and convincing evidence that the cause of claimant's condition and impairment is unrelated to his employment as a fire fighter. ORS 656.802(4).

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 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 28, 1993 is affirmed. For services on review, claimant's attorney is awarded $1,000 payable by the employer.

In the Matter of the Compensation of
ROSALIE S. DREWS, Claimant
WCB Case Nos. 90-05597 & 90-15186
ORDER DENYING RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney
David O. Horne, Defense Attorneys

On March 10, 1994, we issued an Order on Remand which found Wausau Insurance Companies responsible for claimant's low back condition. Asserting that evidence concerning claimant's "post-hearing" surgery supports a conclusion that claimant's preexisting condition experienced a major change, Wausau seeks reconsideration of our decision for admission into the record of this additional evidence. Inasmuch as our March 10, 1994 order has become final, we lack authority to reconsider our decision.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, we issued our Order on Remand on March 10, 1994. Since the 30th day from our order was Saturday, April 9, 1994, the final day for us to alter our decision was Monday, April 11, 1994. See Anita L. Clifton, 43 Van Natta 1921 (1991). As represented by its certificate of mailing, Wausau's motion for reconsideration was mailed to the Board on April 8, 1994. The motion was received by the Board at 3:22 p.m. on April 11, 1994, the last day we were authorized to alter the decision. Unfortunately, the motion was not brought to our attention until the following day, by which time our authority to reconsider our March 10, 1994 order had expired.

The Board attempts to respond to motions for reconsideration as expeditiously as is possible. Irwin W. Geer, 44 Van Natta 1509, on recon 44 Van Natta 1694 (1993), aff'd Geer v. SAIF, 121 Or App 647 (1993); Connie A. Martin, 42 Van Natta 495, on recon 42 Van Natta 853 (1990). Nevertheless, the Board is under no obligation to reconsider its orders and the ultimate responsibility for preserving the viability of a Board order and a party's rights of appeal must ultimately rest with the parties. Connie A. Martin, supra.

Accordingly, inasmuch as our March 10, 1994 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its issuance, we are without authority to reconsider the decision. Accordingly, Wausau's motion for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANDREW B. BAIRD, Claimant
WCB Case Nos. 92-11894 & 92-00144
ORDER ON REVIEW
Lucas & Associates, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Podnar's order which: (1) reduced claimant's award of unscheduled permanent disability for a low back injury from 19 percent (60.80 degrees), as granted by an Order on Reconsideration, to 13 percent (41.6 degrees); (2) reduced claimant's award of scheduled permanent disability for loss of use or function of his right leg from 9 percent (13.5 degrees), as granted by the Order on Reconsideration, to zero; (3) found claimant to be medically stationary on April 18, 1991; and (4) authorized the self-insured employer to offset temporary disability paid after April 18, 1991. On review, the issues are extent of permanent disability (unscheduled and scheduled), medically stationary date, and offset. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 13 percent unscheduled permanent disability for the low back, but no permanent disability for the right leg. The Referee also found claimant to be medically stationary as of April 18, 1991, whereas an Order on Reconsideration had established a July 22, 1991 date. We affirm the Referee's permanent disability awards, but reinstate the Order on Reconsideration's "medically stationary" date.

Claimant sustained a compensable low back strain on June 2, 1990. He initially sought treatment from a Washington osteopathic physician, Dr. Christiansen, who is not licensed to practice in Oregon. (Ex. 72). In December 1990, Dr. Christiansen eventually referred claimant to Dr. Markham, a Washington neurosurgeon.

On April 18, 1991, after determining that there was no operable lesion in claimant's lumbar spine, Dr. Markham stated that claimant should be considered medically stationary on June 1, 1991. Dr. Markham further recommended retraining because claimant did not appear able to do the repetitive bending and lifting of his regular plumbing employment. (Ex. 38). Dr. Markham later declared claimant medically stationary as of April 18, 1991, but refused to rate claimant's permanent disability. (Ex. 46).

In the meantime, Dr. Christiansen continued to attribute claimant's low back and right leg problems to a herniated L5-S1 disc. (Ex. 41). On June 21, 1991, Dr. Christiansen opined that claimant had a 50 percent loss of back function and a 50 percent loss of right leg function due to sciatica and femoral neuropathy. (Ex. 49). On July 22, 1991, in response to an inquiry as to whether claimant was medically stationary, Dr. Christiansen reported that claimant had not experienced any meaningful improvement in his back and leg conditions. (Ex. 51).

The claim was subsequently closed by Notices of Closure on August 1, 13, and 26, 1991, all of which found claimant medically stationary on July 22, 1991. Claimant was also awarded 19 percent unscheduled permanent disability and 9 percent scheduled permanent disability for loss of use or function of his right leg. Finally, claimant was awarded temporary total disability from June 21, 1990 through July 22, 1991. The December 13, 1991 Order on Reconsideration affirmed the Notices of Closure in all respects.

On August 4, 1992, a partial denial was issued. Among the denied conditions were claimant's right femoral nerve, right quadriceps weakness, right femoral neuropathy, herniated nucleus pulposus and right S-1 radiculopathy. The denial was not appealed and became final by operation of law.

The Referee, citing ORS 656.005(12)(a)(A) and OAR 436-35-005(3)(a), determined that Dr. Markham was the only doctor who qualified as claimant's attending physician. The Referee, therefore, relied on Dr. Markham's reports in evaluating claimant's disability. ORS 656.245(3)(b)(B).

Finding that Dr. Markham's April 18, 1991 medical report supported a 5 percent "chronic condition" award, the Referee then added this figure to the undisputed total of claimant's social and vocational factors, 8, for a total unscheduled award of 13 percent. The Referee then reduced claimant's scheduled award to zero because Dr. Markham's reports did not document impairment in claimant's right leg. Finally, the Referee found claimant medically stationary on April 18, 1991, based on Dr. Markham's June 6, 1991 report. Consequently, the self-insured employer was authorized to recover an overpayment of temporary disability paid after April 18, 1991.

Extent of Disability

The Referee refused to consider Dr. Christiansen's medical reports in rating claimant's disability because Dr. Christiansen was not licensed to practice in the State of Oregon. The pertinent portion of ORS 656.005(12)(a)(A) defines an attending physician as "a medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the state of Oregon or a board certified oral surgeon licensed by the Oregon Board of Dentistry."

Claimant argues that Dr. Christiansen should be considered claimant's treating physician given his extensive familiarity with claimant's condition. He also cites OAR 436-35-005(3)(B), which defines an "attending physician" as including a doctor of osteopathy licensed under the laws of another state.[1] The employer responds by asserting that the administrative rule on which claimant relies is in conflict with the statute and, therefore, should be considered ineffective. We need not resolve this "attending physician" question for the following reasons.

Even if Dr. Christiansen could qualify as claimant's attending physician, his medical opinion would not support an increased award of unscheduled or scheduled permanent disability. Dr. Christiansen has opined that claimant's permanent disability in his low back and in his right leg are due to a herniated disc and related sciatica and femoral neuropathy. The employer's August 4, 1992 partial denial included these conditions and was not appealed. It became final by operation of law. Since claimant's permanent impairment must be due to his compensable injury (ORS 656.214(5)), he is not entitled to permanent disability for conditions listed in the August 4, 1992 partial denial, which are now considered noncompensable.

Claimant also cites nerve conduction studies which Dr. Kim interpreted as showing L5-S1 nerve involvement. (Ex. 27). Claimant contends that his injury rendered this previously asymptomatic preexisting condition symptomatic, thus making it disabling and compensable. However, Dr. Kim stated that this condition was inactive. (Ex. 29-1). Moreover, Dr. Rosenbaum, an examining physician, opined that Dr. Kim's finding was not related to claimant's compensable injury. (Ex. 65). While we do not consider Dr. Rosenbaum's opinion on the issue of the extent of claimant's impairment, we do find it probative on the issue of whether claimant's impairment is "due to" his compensable injury. See Frank H. Knott, 46 Van Natta 364 (1994). Inasmuch as we do not find that claimant has additional permanent impairment "due to" his compensable injury, claimant is not entitled to increased unscheduled permanent disability or to an award of scheduled permanent disability.

Medically Stationary Date

Claimant next contends that the correct medically stationary date is July 22, 1991, as indicated in Dr. Christiansen's medical report of that date. We agree.

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[1] We note that there is no evidence whether Dr. Markham is licensed to practice in the State of Oregon. Therefore, it is not clear whether he can qualify as claimant's attending physician. However, we need not consider whether the case should be remanded to the Referee for further evidence. See Arlene J. Koitzsch, 44 Van Natta 136 (1992), aff'd on recon 44 Van Natta 776 (1992), reversed, Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). Since the employer has not cross-appealed claimant's award of unscheduled permanent disability, we will not further reduce it on appeal. Accordingly, a remand is unnecessary.

"Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. See Harmon v. SAIF, 54 Or App 121 (1981); Austin v. SAIF, 48 Or App 7 (1980).

OAR 436-30-035(1) states that a claimant's condition is medically stationary when the attending physician or a preponderance of medical opinion declares the claimant to be medically stationary or stable. When there is a conflict of medical opinion on the medically stationary issue, the most weight is given to medical opinions based on the most accurate history, the most objective findings, on sound medical principles, and clear and concise reasoning. OAR 436-30-035(2).

Here, the Referee relied on Dr. Markham's July 22, 1991 opinion that claimant was medically stationary on April 18, 1991. However, we find that Dr. Markham's opinion is contradictory since he had previously stated that claimant would be medically stationary on June 1, 1991. Dr. Markham offered no explanation for his change of opinion, nor did he offer any reasoning for his opinion that claimant was medically stationary on April 18, 1991. For these reasons, we do not defer to Dr. Markham's opinion on the medically stationary issue. Instead, we adopt Dr. Christiansen's well-reasoned opinion that claimant reached maximum medical improvement on July 22, 1991 and find claimant to have been medically stationary on that date. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we reinstate claimant's award of temporary disability made in the Notices of Closure (as affirmed by the Order on Reconsideration).

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 April 18, 1991 and reinstated the temporary disability award made in the Notices of Closure (and affirmed by the Order on Reconsideration). 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 until July 22, 1991.

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 April 18, 1991 and July 22, 1991, not to exceed $3,800. OAR 438-15-055(1).

However, in lieu of the procedure set forth in Jacobson for recovery of an "out-of-compensation" attorney fee where the compensation has already been paid, claimant's attorney should seek recovery of the fee from claimant in the manner set forth in Jane A. Volk, 46 Van Natta 681 (1994).[2]

ORDER

The Referee's order dated June 9, 1993 is affirmed in part and modified in part. Claimant's April 18, 1991 medically stationary date as found by the Notices of Closure and Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an approved fee of 25 percent of the "increased" temporary disability benefits created by this order (temporary disability payable between April 18, 1991 and July 22, 1991), not to exceed $3,800. This fee shall be recovered by claimant's attorney in the manner set forth in this order. The remainder of the Referee's order is affirmed.

[2] Board Member Gunn directs the parties to his dissent in Volk, supra.

In the Matter of the Compensation of
DENNIS BARTOW, Claimant
WCB Case No. 92-13845
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Russell D. Bevans, Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Black's order that: (1) declined to admit into evidence an unexecuted wage dispute preliminary determination from the Bureau of Labor and Industries (BOLI); and (2) upheld the SAIF Corporation's denial, on behalf of the alleged noncomplying employer, of claimant's injury claim. With his brief, claimant has re-submitted the BOLI determination. We treat such a submission as a motion for remand. ORS 656.295(5). On review, the issues are remand, subjectivity and compensability. We deny the motion for remand and affirm the Referee's order.[1]

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Following issuance of the Referee's Opinion and Order, claimant requested reconsideration, submitting a BOLI determination that was not in existence at the time of hearing. The Referee declined to reopen the record to admit the BOLI document into evidence. On review, claimant moves to remand this case to the Referee for inclusion of the BOLI determination.

Claimant contends that the Referee erred in finding that he was a "casual worker" pursuant to ORS 656.027(3)(b) because claimant's work in any 30-day period did not involve a total labor cost of more than $200. Claimant argues that the BOLI determination establishes that the employer improperly paid him less than the minimum wage. Thus, claimant contends that his earnings for the employer totaled more than $200.

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

Here, the Referee found that the BOLI document was unsigned and undated and, furthermore, it was merely a preliminary determination, rather than a final order. For those reasons, the Referee found that the exhibit was not relevant and declined to admit it into evidence.

We agree with the Referee's ruling. In Eric S. Gehrs, 45 Van Natta 1727 (1993), we concluded that a BOLI determination pertaining to the claimant's termination might constitute probative, material evidence on a question of fact (indeed, it might have preclusive effect on that question), if it constituted a final order after a full evidentiary hearing. However, the BOLI determination was not probative evidence because, rather than a final order after a full hearing on the merits, it was merely a preliminary step in BOLI's administrative process, which could, perhaps, someday lead to formal charges and a hearing in court on the complaint the claimant had filed with BOLI.

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[1] As a preliminary matter, we note that the Referee's order directed the parties to appeal this case to the Court of Appeals. However, we find that the Board is the proper forum for this appeal and we conclude that we have jurisdiction over this matter. See ORS 656.283(1); 656.704(3); Douglas Fredinburg, 45 Van Natta 1619 (1993).

The same is true in the present case. Here, the document is not a final order after a contested case hearing. Rather, it appears to be an unsigned draft of a "proposed" order, issued as part of an administrative process that is preliminary to a contested case hearing, should a hearing be requested after the document is formally issued. Thus, even had the record been held open for it, the BOLI document would not have constituted evidence that a reasonable person would rely on in the conduct of his own affairs. In other words, on the basis of this document, this Board could not resolve the question of subjectivity that is presented. Accordingly, the record was not insufficiently developed for lacking the BOLI document. Claimant's motion for remand is, therefore, denied.

Subjectivity/Compensability

We adopt the Referee's "Conclusions of Law and Reasoning," on these remaining issues.

ORDER

The Referee's order dated March 9, 1993, as reconsidered July 6, 1993, is affirmed.

April 13, 1994 Cite as 46 Van Natta 713 (1994)

In the Matter of the Compensation of
WESLEY R. CRADDOCK, Claimant
WCB Case No. 93-04571
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of that portion of Referee Peterson's order that awarded claimant an insurer-paid attorney fee under ORS 656.386(1) for finally prevailing without a hearing against SAIF's "de facto" denial of several conditions which SAIF had not previously specifically accepted. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury on July 27, 1992, involving multiple injuries to his head and body. Numerous diagnoses were subsequently made. SAIF wrote claimant on October 22, 1992 and advised that the claim would be accepted for certain listed conditions. The Notice of Acceptance specifically stated that "we accept the responsibility only for the conditions specified above. If you feel that your claim should also cover other conditions, contact SAIF Corporation within 10 days of the date on this notice." (Ex. 2, emphasis supplied).

On April 15, 1993, claimant requested a hearing, raising the issue of "de facto" denial and penalties for SAIF's failure to provide a notice of acceptance for all of claimant's diagnosed conditions resulting from his industrial injury. On May 27, 1993, SAIF wrote claimant's attorney that, although it was true that SAIF had not accepted all of claimant's conditions in writing, all of them had been accepted. (Ex. 25). Further, claimant was advised that all benefits had been paid. On the day before the hearing, SAIF formally amended its acceptance to include all of claimant's conditions diagnosed as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee held that SAIF's failure to timely accept in writing all of claimant's conditions caused by the compensable injury constituted a "de facto" denial. Noting that SAIF's amended acceptance occurred only after claimant's request for hearing, the Referee further reasoned that claimant was entitled to an assessed attorney fee under ORS 656.386(1) for his counsel's efforts in securing acceptance of all of claimant's previously unaccepted medical conditions due to his compensable injury.

SAIF contends that the Referee erred in finding a "de facto" denial. Specifically, it notes that it issued a written notice of acceptance (although it did not include all diagnosed conditions), paid all benefits, never issued a denial, and sent an amended notice of acceptance to claimant to formally include all diagnosed conditions. Citing SAIF v. Tull, 113 Or App 449 (1993), SAIF asserts that a written notice of acceptance is not a prerequisite to an "acceptance" and that acceptance of a claim is a question of fact. In light of its actions, SAIF contends that it never denied, "de facto" or otherwise, claimant's claim. We disagree.

SAIF correctly states that whether acceptance of a claim has occurred is a question of fact. SAIF v. Tull, supra. Here, we find, as a factual determination, that SAIF denied the compensability of the conditions for which claimant's counsel was instrumental in obtaining acceptance. The best evidence of SAIF's intentions is contained in its initial acceptance letter. There, SAIF specifically limited its acceptance to the conditions listed in the letter. Although SAIF now contends that it initially accepted all conditions resulting from claimant's injury, we are more persuaded by the express language of its initial acceptance letter than SAIF's subsequent assertions.

Moreover, the fact that SAIF has paid all benefits does not alter our conclusion. The mere payment of benefits does not constitute acceptance of a claim. ORS 656.262(9); Euzella Smith, 44 Van Natta 778 (1992). Although SAIF eventually amended its notice of acceptance to include all diagnosed conditions, this was done after a request for hearing had been filed. We consider this action to further support our conclusion that all conditions were not accepted at the inception of the claim. Finally, the absence of a denial is not significant. It is well-settled that insurer inaction is neither acceptance nor denial. Johnson v. Spectra Physics, 303 Or 49, 58 (1987). Here, however, SAIF did not fail to act. Rather, in limiting its acceptance to certain conditions, SAIF "in fact" denied the other conditions which had been diagnosed as resulting from the July 27, 1992 injurious event.

In summary, our review of the record persuades us that SAIF did not accept all of the diagnosed conditions resulting from claimant's injury until more than 90 days had elapsed since notice or knowledge of the claims. Therefore, we find that a "de facto" denial occurred. Safeway Stores, Inc., v. Smith, 117 Or App 224 (1992); Barr v. EBI Companies, 88 Or App 132, 134 (1987).

The issue then becomes whether or not claimant is entitled to an assessed attorney fee pursuant to ORS 656.386(1). The language in SAIF's initial acceptance letter created a dispute over the causation of the unaccepted conditions.

Inasmuch as causation was at issue until SAIF "rescinded" its "de facto" denial and amended its acceptance the day before the hearing, we find that an assessed attorney fee under ORS 656.386(1) was appropriately awarded. See Betti A. Haley, 46 Van Natta 205, 206 n.1 (1994) (SAIF v. Allen, 124 Or App 183 (1993), distinguished. Where "de facto" denial of shoulder condition not rescinded until hearing, attorney fee under ORS 656.386(1) appropriate because causation was at issue until rescission.). Finally, we note that claimant is not entitled to an attorney fee award for services on review concerning the Referee's attorney fee award. Dotson v Bohemia, Inc, 80 Or App 233 (1986).

ORDER

The Referee's order dated August 20, 1993 is affirmed.

In the Matter of the Compensation of
ROSE L. DIXON, Claimant
WCB Case No. 93-03057
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband, Gunn and Haynes.

The self-insured employer requests review of Referee Michael V. Johnson's order that: (1) awarded 5 percent (7.5 degrees) scheduled permanent disability for a right wrist condition, whereas an Order on Reconsideration awarded none; and (2) declined to authorize offset of previously overpaid temporary disability compensation. Claimant cross-requests review, seeking an attorney fee for prevailing on the offset issue. On review, the issues are extent of permanent disability (scheduled), offset, 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 Disability

The Referee awarded 5 percent scheduled permanent disability for claimant's chronic right wrist condition. We agree and adopt his opinion on this issue, with the following comments.

In this case, we find that the persuasive opinions of Dr. Whitney, treating physician, and Dr. Smith, medical arbiter, establish that claimant has a permanent chronic right wrist condition which causes at least a partial inability to use that body part. In reaching this conclusion we particularly note Dr. Smith's statement, "I agree with Dr. Whitney that [claimant's] wrist would not stand up to any activity which required repetitive use of the wrist or hand." (Ex. 15-3-4; see Exs. 11, 14). As we understand the express medical restrictions and the record as a whole, claimant is presently unable to perform repetitive right wrist activities due to her compensable chronic right wrist condition.[1] Accordingly, we conclude that she is entitled to permanent disability award under OAR 436-35-010(6).

Offset/Attorney Fees

The Referee held that the employer is barred from requesting authorization to offset previously overpaid temporary disability compensation, because it did not raise the issue on reconsideration of the Notice of Closure. We disagree.

Since the Referee's order, we have held that a party may litigate an issue at hearing that was not previously raised on reconsideration. See Darlene K. Bentley, 45 Van Natta 1719 (1993) (Extent of disability issues not raised on reconsideration may be raised at hearing); Ruth E. Griffin, 46 Van Natta 418 (1994) (Premature closure may be raised at hearing, even if not raised on reconsideration); Hugh D. Brown, 45 Van Natta 2188 (1993).

Accordingly, because a $430.97 overpayment is established, the employer is hereby authorized to offset this amount against claimant's permanent disability award. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986). Furthermore, claimant's request for an attorney fee for prevailing on the offset issue is now moot. Parenthetically, even if we did not authorize an offset, no attorney fee would be awardable on that basis. See Strazi v. SAIF, 109 Or 105 (1991).

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[1] The dissent relies on superficially similar cases, where we declined to award permanent disability for chronic conditions based on medical restrictions against repetitive use. To the extent that the dissent represents these cases as standing for a rule that such restrictions are categorically insufficient to prove a ratable chronic condition, the interpretation is overbroad. We decide each case on its own facts.

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

ORDER

The Referee's order dated August 11, 1993 is reversed in part and affirmed in part. That portion of the order that declined to authorize offset is reversed. The self-insured employer is authorized to offset its $430.97 overpayment against claimant's permanent disability award. The remainder of the order is affirmed. For services on review for successfully defending claimant's permanent disability award, claimant's counsel is awarded a $750 attorney fee, payable by the employer.

Board Member Haynes dissenting.

The majority awards permanent disability based on medical evidence recommending that claimant refrain from using her right wrist and hand to avoid reinjury. I disagree, for the following reasons.

First, the Board has previously held that a limitation against repetitive use, when imposed to avoid the likelihood of reinjury, is not sufficient to establish entitlement to a permanent disability award for a chronic condition. See Douglas L. Tyree, 46 Van Natta 518 (1994); David A. Kamp, 46 Van Natta 389 (1994); Rae L. Holzapfel, 45 Van Natta 1748 (1993).

Second, even if the majority's conclusion was legally consistent with Board precedent, I would conclude that claimant has not proven permanent injury-related impairment on these facts. No physician is able to explain claimant's continuing complaints. Instead, the medical evidence uniformly indicates that claimant's pain is not supported by objective findings.

Dr. Smith, medical arbiter, reported that claimant's "wrist continues to be symptomatic despite an absence of any objective findings to account for her pain." (Ex. 15-3). He opined, "Based on purely objective findings, I can find no reason why she would be unable to repetitively use her wrist." (Ex. 15-4). Dr. Whitney, treating physician, predicted "[I]t is not likely that [claimant] could return to a job of repetitive use of the hand without recurrent problems." (Ex. 14, emphasis added). Dr. Whitney did not say that claimant is unable (or partially unable) to use her right hand or wrist repetitively. Instead, he predicted that she will have future problems if she does perform repetitive use activities.

Permanent disability benefits are meant to compensate injured workers for existing injury-related disability, not for speculative future problems. Accordingly, on this record, I would find that claimant is not presently entitled to a permanent disability award for a chronic right wrist condition.

In the Matter of the Compensation of
ELAINE HENRY, Claimant
WCB Case Nos. 92-08549 & 92-12715
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Brown's order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer in April 1990 as a health insurance examiner. Her work requires her to drive approximately 100 miles per day mainly in traffic. She conducts six to eight physical examinations per day. As part of the examination, she inflates a blood pressure cuff at between two and four times for each patient. Inflating the blood pressure cuff requires claimant to squeeze the bulb between three and ten times depending on the size of the patient. For each patient, claimant fills out a six part, sixteen line form with a ballpoint pen.

In April 1991, claimant began experiencing numbness in her right hand. She sought treatment for this symptom from Dr. Johnson, general practitioner. Dr. Johnson referred claimant to Dr. Grant for electrodiagnostical studies. Claimant's condition was eventually diagnosed as bilateral carpal tunnel syndrome. In late November, claimant underwent right carpal tunnel release surgery which was performed by Dr. Maurer.

Claimant is 53 years of age and right-handed. Claimant has only one functioning kidney with resulting hypertension. Claimant also has peripheral neuropathy in her upper extremities which is idiopathic.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that her work activities were the major cause of her bilateral carpal tunnel condition. We disagree.

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition, or in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. ORS 656.802(2); Dethlefs v. Hyster Co., 295 Or 298 (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).

Dr. Grant, claimant's treating physician, opined that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. His opinion is supported by Dr. Johnson who also relates claimant's carpal tunnel syndrome directly to work activities.

Conversely, Dr. Radecki, an examining physician, relates claimant's condition to her peripheral neuropathy, aging and menopause. His opinion is supported by Dr. Button, also an examining physician, who relates claimant's carpal tunnel syndrome to her abnormal kidney, as well as the factors listed by Dr. Radecki.

When medical experts disagree, we tend to give greater weight to the conclusions of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985). Here, we find no reasons not to defer to the opinion of Dr. Grant. Dr. Grant persuasively explains why claimant's peripheral neuropathy, her age and her menopausal state are not causative in her carpal tunnel syndrome. (Exs. 22, 26). In addition, Dr. Johnson reported that claimant's kidney function is normal and that she does not retain fluid. (Ex. 21).

By contrast, Drs. Radecki and Button identified those factors only in the sense of the general population and not specifically to claimant. Moreover, Dr. Button does not explain how claimant's abnormal kidney is causative where the kidney function is normal and claimant does not retain fluid. For these reasons, we are not persuaded by the opinions of Drs. Radecki and Button. See Sherman v. Western Employers Insurance, 87 Or App 602 (1987).

Based on the opinion of Dr. Grant, as supported by Dr. Johnson, we find that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. Accordingly, we conclude that the condition is compensable.

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 assessed attorney fee for claimant's counsel's services at hearing and on review 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 briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 7, 1993 is reversed in part and affirmed in part. That portion which upheld the SAIF Corporation's denial is reversed. SAIF's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $2,500, payable by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
MATTHEW J. HILGER, Claimant
WCB Case No. 93-03384
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Schultz's order that increased claimant's unscheduled permanent disability for a low back condition from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to 28 percent (89.6 degrees). On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for that portion stating that "it appears from [Dr. Martens'] report that the measurements [for claimant's spinal range of motion] were only taken once."

CONCLUSIONS OF LAW AND OPINION

An Order on Reconsideration reduced claimant's permanent disability from 19 percent to 17 percent. The Referee increased the award to 28 percent. The Referee deferred to a physical therapist's range of motion findings rather than those of Dr. Martens, a medical arbiter, determining that Dr. Martens measured each range of motion only one time and, therefore, his readings were less probative.

We disagree with the Referee's evaluation of the medical evidence. First, as the Referee noted, the Director has issued a Bulletin requiring that examiners take at least three consecutive range of motion measurements. Here, however, claimant did not challenge admission of Dr. Martens' report into evidence on the grounds that it was not based on three consecutive range of motion measurements. Furthermore, there is no evidence in the record that would support a finding that three consecutive measurements were not taken by Dr. Martens. Therefore, the record contains an insufficient basis to conclude that Dr. Martens' testing procedures were flawed, thereby rendering his test results invalid or less probative.

The question, then, is whose findings should be adopted for purposes of the award, the physical therapist's or Dr. Martens'. We conclude, Dr. Martens'. OAR 436-35-007(a) provides, in relevant part: "...on reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." See Carlos S. Cobian, 45 Van Natta 1582 (1993); Joaquin M. Betancourt, 44 Van Natta 1762 (1992). On this record, where the evidence is in equipoise, we find no reason to reject the measurements of impairment recorded by Dr. Martens, the medical arbiter.

According to Dr. Martens, claimant's flexion was 66 degrees, resulting in 0 percent impairment, OAR 436-35-360(19); extension was 20 degrees, resulting in 2 percent impairment, OAR 436-35-360(20); right lateral flexion was 30 degrees, resulting in 0 percent impairment, OAR 436-35-360(21); and left lateral flexion was 24 degrees, resulting in .2 percent impairment, OAR 436-35-360(21). These values are added for a total of 2.2 percent impairment. See OAR 436-35-360(22). That factor is rounded to the nearest whole number. See OAR 436-35-007(11). Therefore, claimant is entitled to 2 percent impairment for loss of spinal motion.

The parties stipulated that claimant was entitled to 11 percent for surgery. Combining that value with the 2 percent impairment value results in a value of 13 percent. The parties further stipulated that the appropriate value for claimant's age, education and adaptability is 4 percent, which is added to the impairment value. See OAR 436-35-280(7). Claimant, therefore, is entitled to 17 percent unscheduled permanent disability.

In light of this conclusion, we find it unnecessary to address SAIF's assertion that the Referee improperly denied its motion for reconsideration in which it requested that the Referee reopen the record in order to admit evidence showing that Dr. Martens had complied with testing procedures by measuring claimant's range of motion three times.

ORDER

The Referee's order dated June 22, 1993 is reversed. In lieu of the Referee's award, the Order on Reconsideration award of 17 percent (54.4 degrees) unscheduled permanent disability is reinstated and affirmed.

In the Matter of the Compensation of
RICKIE S. KROHNKE, Claimant
WCB Case No. 93-04481
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of that portion of Referee McCullough's order that recalculated claimant's rate of pay and awarded additional temporary disability benefits. On review, the issue is calculation of temporary disability benefits. We reverse.

FINDINGS OF FACT

Claimant worked for the employer, who was headquartered in Pleasant Hill, Oregon, near Eugene, off and on as a driller's helper from sometime in 1987 until August 1991. His pay started at $7 per hour and was eventually raised to $9 per hour for non-union work. The prevailing non-union wage for driller's helpers in Oregon is $6 to $10 per hour. (Tr. 38 and 39). When overnight travel from home was required, the employer paid for claimant's meals and lodging. Otherwise, meals and lodging were not reimbursed.

In January 1991, the employer asked claimant to work in California. Claimant worked in California from January 31, 1991 through August 1991. During this period, he also worked for the employer in the Eugene area. The employer paid claimant $9 per hour plus overtime for non-union work. The employer also paid meals and lodging in California, but not when claimant worked in the Eugene area.

On April 29, 1991, while working in California, claimant injured his low back. He filed a workers' compensation claim, which SAIF originally accepted as nondisabling but was subsequently determined to be disabling.

The employer had gone to California in 1990 to set up a California corporation to do his California drilling business. This business was not ready to operate when claimant accepted the California assignment, so he worked under the Oregon corporation. The employer's intention was eventually to have claimant perform work in California as an employee of the California corporation. Prior to claimant's quitting his job in August 1991, the employer began to transition to a different compensation arrangement, in which the employer would pay claimant for drilling services by the footage he drilled, and claimant would pay his own room and board.

The temporary disability compensation SAIF paid to claimant was based on a weekly wage rate of $285.06, which was calculated based upon claimant's hourly rate plus overtime paid from January 31, 1991 to May 4, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee, citing Russell F. Fouts, 38 Van Natta 418 (1986), concluded that the room and board expenses claimant received at the time of injury should be included in the SAIF Corporation's calculation of claimant's wages for temporary disability compensation. SAIF contends that room and board are travel expenses, not wages. We agree.

"Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. ORS 656.005(27).

In Fouts, supra, the claimant received free rent in exchange for his services as a camp host. The Board interpreted the free rent advantage received by the claimant as included in the statutory definition of wages pursuant to former ORS 656.005(26) (since renumbered ORS 656.005(27)). Here, in contrast, we do not consider the payment of room and board by claimant's employer to be the kind of "advantage" to be included as wages pursuant to ORS 656.005(27) for the following reasons.

Claimant, a driller's helper, has an accepted disabling low back claim with the employer. From 1987 until 1991, claimant was hired at an hourly rate for non-union work, which increased from $7 an hour in 1987 to $9 an hour in 1991. The employer did not pay for claimant's food or housing in addition to this amount. However, the employer consistently paid for lodging and meals when a job required an overnight stay away from the Pleasant Hill/Eugene area. When the employer asked claimant to work in California for an extended period of time, he and claimant agreed that claimant would be paid $9 an hour plus overtime. The employer also agreed to pay claimant's room and board in California.

Claimant contends that he would not have taken the job in California had the employer not paid his room and board. We understand this contention to imply that room and board were part of claimant's remuneration for his services rather than reimbursement for travel expenses.

In order to establish whether the parties agreed that payment of room and board was in exchange for claimant's services, we examine the evidence regarding the contract of hire in force at the time of the accident. See Dale J. Lindamood, 44 Van Natta 1112 (1992). Here, we conclude that claimant's contract of hire was no different when he agreed to work in California from that at the time of his initial employment in 1987. First, the employer continued to pay claimant an hourly wage at the going rate for non-union work in Oregon, plus overtime, as he had since claimant had begun working for him. This wage was paid in both Oregon and California. In addition, consistent with the usual practice prior to claimant's going to California, the employer paid room and board while claimant was away from the home base overnight, but not while claimant was working in the Eugene area. Thus, there is no persuasive evidence that the parties agreed that claimant was to receive room and board as compensation for his services, in addition to the hourly rate plus overtime, simply because claimant accepted employment in California.

Rather, we conclude that it was the employer's ongoing practice to pay claimant's travel expenses while working away from home. This conclusion is further supported by the fact that claimant's meal expenses were reimbursed by the employer.

Furthermore, the change in remuneration to a different method of payment, i.e., commission on footage drilled and no room and board, is consistent with the employer's establishment of a California business, rather than proof that meals and lodging were meant to be compensation for claimant's work.

OAR 436-60-025(4)(a) states in pertinent part:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average."

SAIF computed claimant's temporary disability compensation on a weekly wage rate calculated on claimant's hourly rate plus overtime paid from January 31, 1991 to May 4, 1991. We conclude that SAIF's calculation was correct, and that claimant has not sustained his burden of proving entitlement to a higher rate of temporary disability compensation.

Because we have concluded that SAIF correctly calculated claimant's temporary disability rate, penalties and attorney fees are not appropriate.

ORDER

The Referee's order dated August 3, 1993 is reversed in part and affirmed in part. That portion of the order that directed the SAIF Corporation to recalculate claimant's temporary disability rate and awarded claimant's attorney an "out-of-compensation" attorney fee is reversed. The remainder of the order is affirmed.

April 13, 1994 Cite as 46 Van Natta 721 (1994)

In the Matter of the Compensation of
ELIZABETH D. MILLER, Claimant
WCB Case No. 93-03353
ORDER ON REVIEW (REMANDING)
Gatti, et al., Claimant Attorneys
Shannon, et al., Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Byung Tea Jun (Jun), a noncomplying employer, requests review of that portion of Referee Howell's order that dismissed Jun's request for hearing concerning the SAIF Corporation's acceptance of claimant's low back injury claim on the basis that the hearing request was untimely. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

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

On October 8, 1992, the Department of Insurance and Finance (DIF) issued a Proposed and Final Order finding Jun to be a noncomplying employer. (Ex. 14). The same day, DIF referred claimant's claim to SAIF for processing. (Ex. 12). The bottom of the letter stated, "cc: * * * (w/notice): Byung Tea Jun." (Id.)

By Notice of Acceptance dated January 19, 1993, SAIF accepted claimant's L5-S1 disc herniation. (Ex. 25). By letter dated March 17, 1993, Jun requested a hearing to contest SAIF's acceptance. (Ex. 29).

The Referee found that Jun had not timely requested a hearing concerning SAIF's acceptance of claimant's low back injury claim. Therefore, the Referee concluded that the Hearings Division did not have jurisdiction over Jun's hearing request. Accordingly, the Referee dismissed Jun's hearing request.

CONCLUSIONS OF LAW AND OPINION

Jun argues that his request for hearing was not untimely because, under ORS 656.283(1) and Blain v. Owen, 106 Or App 285 (1991), he could request a hearing to challenge SAIF's acceptance of claimant's low back injury claim at any time. Rather than repeat our analysis, we refer the parties to Thomas R. Lee, 46 Van Natta 69 (1994), wherein we rejected that very same argument.

ORS 656.054(1) was amended in 1991. See Or Laws 1991, ch 679, § 1.[1] As amended, that statute provides that the Director shall refer to SAIF a claim for an injury to a subject worker while in the employ of a noncomplying employer within 60 days of the date the Director has notice of the claim.

At the time of referral, the Director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. ORS 656.054(1); Thomas R. Lee, supra. The employer then has 90 days within which to request a hearing to object to the claim. Thomas R. Lee, supra; Donald L. Grant, 44 Van Natta 1854 (1992); see ORS 656.262(6); ORS 656.054(1). Thus, the question is one of due process: Did Jun receive notice from the Director (DIF) regarding his right to object to the claim? See Thomas L. Lee, supra.

It appears that DIF may have complied with the notice requirement of ORS 656.054(1). However, on this record, we cannot reach that conclusion with any certainty. DIF's referral letter (Ex. 13) indicates that the letter was copied to Jun with "notice." However, nothing in the record indicates what that "notice" consisted of. Exhibit 14 includes a "notice" regarding the Director's noncomplying employer determination. (This notice advises the employer of a 20-day period within which to challenge the noncomplying employer determination. See ORS 656.740.) Exhibit 14 does not contain the "notice" required by ORS 656.054(1). On this record, we are unable to ascertain whether Jun received proper notice of his right to request a hearing to object to the claim. See Thomas L. Lee, supra.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Because the resolution of the jurisdictional issue presented by this case is dependent on whether DIF provided proper notice to Jun, and because we are unable to resolve that issue on the record as presently constituted, we conclude that the record has been incompletely developed.

Accordingly, we vacate the Referee's order and remand this matter to Referee Howell with instruction to reopen the record for the limited purpose of admitting additional evidence regarding whether Jun received notice from the Director regarding his right to object to the claim. The Referee is further instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7). The Referee shall then issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated July 7, 1993 is vacated. The matter is remanded to Referee Howell for further proceedings consistent with this order.

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[1] Amended ORS 656.054(1) became effective on July 25, 1991. Or Laws 1991, ch 679, § 1. Inasmuch as claimant's low back injury occurred on August 2, 1992, the amended version of ORS 656.054(1) applies.

In the Matter of the Compensation of
RUBY M. RIFE, Claimant
WCB Case No. 92-11266
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Nielsen's order that affirmed an Order on Reconsideration that awarded 24 percent (76.8 degrees) unscheduled permanent disability for a cervical injury. On review, the issue is extent of unscheduled permanent disability.

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

Claimant became medically stationary after July 1, 1990, and made a request for reconsideration pursuant to ORS 656.268. Therefore, the applicable standards are those in effect on the date of the April 28, 1992 Notice of Closure. OAR 438-10-010, 436-35-003(2) (WCD Admin. Order 6-1992). Those are the standards applied by the Referee.[1]

On August 7, 1991, claimant was examined by Dr. Woolpert, examining orthopedist, and Dr. McDonald, examining psychologist. (Exs. 3, 4). Dr. Woolpert noted that claimant displayed a significant amount of nonorganic pain behavior, which he opined suggested that there were psychological factors present in claimant's failure to improve. (Ex. 3-4). Dr. McDonald diagnosed somatoform pain disorder and opined that claimant was not medically stationary from a psychological perspective. (Ex. 4-7). He also noted pain and symptom magnification. (Ex. 4-6).

Dr. Forsyth, treating D.O., reviewed the "evaluations" by Drs. Woolpert and McDonald and explicitly concurred with Dr. Woolpert's "evaluation." (Ex. 6, 7). Although he noted that Dr. Woolpert's description of claimant's range of motion was "especially vague," he made no comment regarding Dr. Woolpert's evaluation that claimant displayed significant nonorganic pain behavior. (Ex. 7). In addition, Dr. Forsyth noted that he found Dr. McDonald's report more interesting and wondered if psychotherapy was available as part of "the management" for claimant. (Ex. 7). Furthermore, Dr. Forsyth stated that claimant was "left with a painful condition, whatever the cause." Claimant's psychological condition is not compensable. (Ex. 12).

On December 20, 1991, Dr. Forsyth conducted a closing examination and provided multiple restrictions on claimant's activities. (Ex. 8). In addition, on April 20, 1992, Dr. Forsyth approved a job description for a cashier job but noted that claimant was capable of working at that job only four hours per day for two or three days per week. (Ex. 9A). Claimant urges us to rely on these latter two reports from Dr. Forsyth as proof that her residual functional capacity should be classified as "restricted/sedentary."

However, Dr. Forsyth did not relate the multiple restrictions provided in the closing examination or the limited work hours to the work injury. Given Dr. Forsyth's prior comments about the reports of Drs. Woolpert and McDonald, we find this omission renders his opinion unpersuasive.

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[1] We note that subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant argues that the "[R]eferee was not free to interpret Dr. Forsyth's findings with regard to residual lifting capacity as noncompensable, while reduced range of motion was compensable." However, although claimant raised impairment as an issue in his request for reconsideration, the parties agreed that the sole issue at hearing was claimant's adaptability value. (Tr. 2-3). Therefore, the impairment value was not before the Referee.

ORDER

The Referee's order dated June 7, 1993 is affirmed.

April 14, 1994 Cite as 46 Van Natta 724 (1994)

In the Matter of the Compensation of
GENE C. ADAMS, Claimant
WCB Case No. 93-02513
CORRECTED ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

It has come to our attention that our April 5, 1994 Order on Review contained a clerical error. Specifically, in the introductory paragraph of our decision, we mischaracterized the Referee's order and miscalculated claimant's permanent disability awards. In the interests of correcting these oversights, we replace the opening paragraph of our prior order with the following paragraph.

"Claimant requests review of Referee Holtan's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right foot (ankle) from 10 percent (13.5 degrees), as granted by an Order on Reconsideration, to 11 percent (14.85 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of the left foot (ankle) from 32 percent (43.2 degrees), as granted by an Order on Reconsideration, to 37 percent (49.95 degrees). On review, claimant asserts that the Referee erred in declining to award claimant impairment values for lost ranges of motion in the interphalangeal joints of the toes of his left foot. On review, the issue is extent of scheduled permanent disability."

Accordingly, we withdraw our April 5, 1994 order. As clarified herein, we republish our April 5, 1994 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
MARK A. CRAWFORD, Claimant
WCB Case No. 91-03109
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of those portions of Referee Mongrain's order that: (1) awarded claimant temporary disability benefits from September 4, 1987 to July 1, 1990, with the exception of December 1, 1987 to April 13, 1988; and (2) assessed a penalty for the employer's allegedly unreasonable claim processing. Claimant cross-requests review, contending that he should receive: (1) temporary disability benefits from December 1, 1987 through February 11, 1992; (2) a penalty and related attorney fee based on this amount; (3) interest on temporary disability benefits, penalties and fees, and (4) penalties and fees for the failure to pay interest. Claimant has also moved to supplement the hearing record. On review, the issues are temporary disability, penalties and attorney fees, and interest. We affirm in part and reverse in part.

FINDINGS OF FACT

On July 2, 1987, claimant compensably cut his right middle finger. (Exs. 1 and 4). On July 13, 1987, he quit work for reasons unrelated to his injury. (Exs. 2 and 3). Subsequently, his finger became severely infected. On September 4, 1987, Dr. Balme performed debridement surgery on the finger and diagnosed a developing boutonniere deformity. (Exs. 5, 6, 7 and 8).

On October 7, 1987, the insurer denied payment for temporary disability and some medical bills on the basis that claimant's treatment was not work-related. (Exs. 11 and 12). Claimant filed a request for hearing.

Dr. Balme referred claimant to Dr. Casey for treatment of the boutonniere deformity. On November 12, 1987, Dr. Casey elected to wait for a time to see whether claimant was motivated enough to go through the complex surgical process of a tendon transfer or tendon graft to correct the boutonniere deformity. (Ex. 14). On the same date, Dr. Casey filled out an Employment Division form on which he indicated that claimant was released for full time work without limitation. (Ex. 16).

By a February 18, 1988 stipulation, the employer withdrew its denial.

The employer timely paid temporary disability benefits from September 4, 1987 through September 19, 1987, the period for which claimant was hospitalized for the debridement surgery. (Exs. 23, 24, 28 and 42A-20). The employer then unilaterally terminated temporary disability payments. (Ex. 38-4). On March 9, 1988, claimant's requested payment of the balance of temporary disability due. (Ex. 23).

On April 13, 1988, Dr. Casey scheduled surgery in May to correct the boutonniere deformity. (Ex. 26).

On April 21, 1988, the employer requested suspension of compensation from the Compliance Section, which was refused. (Exs. 28 and 31).

On April 22, 1988, claimant requested a hearing on the issues of temporary disability, medical services, and a penalty and attorney fee for failure to comply with the terms of the stipulation.

On May 5, 1988, the employer partially denied compensability and surgery for claimant's current condition, i.e., the boutonniere deformity. (Ex. 32). The scheduled surgery was cancelled. (Ex. 34). Claimant supplemented his hearing request, adding the issues of compensability, the denial of surgery, and penalties and attorney fees for an alleged unreasonable denial. (Ex. 33).

A hearing was held on July 25, 1988. By a September 30, 1988, Opinion and Order, Referee Leahy upheld the employer's current condition denial and concluded that the employer's refusal of surgery and failure to comply with the stipulation were not unreasonable. He dismissed the matter without addressing the temporary disability issue. (Ex. 42A-18 through 22). Claimant requested Board review.

In a September 28, 1990, Order on Review, the Board reversed Referee Leahy's order, finding claimant's boutonniere deformity compensable and the employer's denial unreasonable. Mark A. Crawford, 42 Van Natta 2098 (1990). It awarded claimant temporary total disability from September 4, 1987 until terminated in accordance with law, subject to offset for any unemployment benefits, temporary disability, or wages received. The Board also awarded an approved fee of 25 percent of the increased temporary disability compensation created by the order; and, for its unreasonable denial, a penalty of 25 percent of the compensation due at the time of hearing; and a penalty-related assessed attorney fee of $300. (Ex. 38). The employer appealed. The Court of Appeals affirmed the order on May 15, 1991, and the Supreme Court denied review on September 24, 1991.

Meanwhile, on October 11, 1990, Dr. Balme responded to a query from the employer, stating that claimant had become medically stationary about December 1, 1987, following the September 4, 1987 surgery. On October 12, 1990, the employer paid temporary disability from September 18, 1987 through December 1, 1987. (Ex. 40 and Stipulated Facts p. 2).

On December 5, 1990, Dr. Casey re-scheduled surgery for the boutonniere deformity. On March 8, 1991, the employer again denied claimant's current condition and payment of a medical bill on the basis that the boutonniere deformity was not compensably related to claimant's July 1987 injury. Surgery was cancelled.

On March 14, 1991, claimant requested a hearing on the denial, raising the issues of compensability and penalties and attorney fees on the basis that compensability of claimant's boutonierre deformity condition had already been litigated. On May 15, 1991, claimant amended the request for hearing, raising the issue of temporary disability.

On December 4, 1991, the employer authorized surgery. (Ex. 52A).

The surgery was performed on February 11, 1992. The employer commenced paying temporary total disability benefits as of the same date. On February 20, 1992, the employer withdrew its March 8, 1991 denial. (Ex. 56).

The hearing in this matter was convened on March 18, 1992. The Referee's order issued on September 25, 1992, awarding, inter alia, temporary total disability from September 4, 1987 to July 1, 1990, with the exception of the period from December 1, 1987 to April 13, 1988, less wages and unemployment compensation and subject to offset for temporary disability already paid for the period between September 18, 1987 and December 1, 1987. The Referee also awarded a penalty equal to 25 percent of these benefits, with one-half of the penalty for the period from July 25, 1988 to July 1, 1990 to be payable to claimant's attorney in lieu of a fee.

On October 8, 1992, subsequent to the Referee's order, the employer issued a Notice of Closure. A January 27, 1993 Order on Reconsideration awarded claimant temporary total disability from September 4, 1987 through November 30, 1987 and from April 13, 1988 through June 30, 1990, less time worked, based on the Referee's September 25, 1992 order. This compensation was stayed pursuant to ORS 656.313. The order also awarded claimant temporary total disability from February 11, 1992 through May 27, 1992 and temporary partial disability from May 28, 1992 through September 15, 1992.

The employer requested a hearing on the Order on Reconsideration, raising the sole issue of claimant's entitlement to temporary partial disability subsequent to July 26, 1992.

By a May 18, 1993 Stipulation, the parties agreed that all issues raised or which could have been raised were settled and that the employer had no obligation to pay temporary disability subsequent to July 26, 1992. The Order on Reconsideration was amended accordingly and has become final.

The Order on Reconsideration, the employer's hearing request, and the stipulation are relevant to the issue of temporary disability. These documents were not obtainable with the exercise of due diligence at the time of hearing.

CONCLUSIONS OF LAW AND OPINION

Administrative Notice

On review, claimant moved to include in the record three documents that issued subsequent to the Referee's order: (1) a copy of a January 17, 1993 Order on Reconsideration; (2) a copy of a February 17, 1993 Request for Hearing filed by the employer to challenge claimant's entitlement to temporary partial disability subsequent to July 26, 1992; and (3) a copy of a May 18, 1993 Stipulation that amended the Order on Reconsideration. The employer has not objected to this request.

We have no authority to consider evidence not in the record. However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Jenetta L. Gans, 41 Van Natta 1791 (1989); Susan K. Teeters, 40 Van Natta 1115 (1988). Furthermore, although a Request for Hearing is not an agency order, it is a document which has procedural significance which enables an evaluation of the evidence. Therefore, we may take administrative notice of it as well. Susan K. Teeters, supra.

Inasmuch as these documents are germane to the issues before us, we take administrative notice of the January 27, 1993 Order on Reconsideration, the employer's February 17, 1993 Request for Hearing, and the May 18, 1993 Stipulation. However, we do not consider claimant's accompanying argument, since it was provided subsequent to filing of the briefs. See Betty L. Juneau, 38 Van Natta 553 (1986).

Temporary Disability Compensation

The Referee concluded that claimant became medically stationary on December 1, 1987 and remained stationary until April 13, 1988, when Dr. Casey requested surgery to correct claimant's boutonniere deformity. The Referee awarded temporary disability compensation from September 4, 1987 to July 1, 1990, less the period that claimant was medically stationary.

On review, the employer makes two arguments. First, it contends that claimant did not cease to be medically stationary until the surgery actually took place on February 11, 1992. Second, it contends that the 1990 amendment of ORS 656.268(3), which changed the requirements for terminating temporary total disability benefits, should apply retroactively to relieve it from paying any temporary disability compensation as of the date any of its provisions could have been applied. Claimant, on the other hand, contends that he is entitled to temporary disability payments from December 1, 1987 to April 13, 1988 and from July 1, 1990 to February 11, 1992, based on the prior Board order.

Applicable Law

We conclude that the Workers' Compensation Act as amended effective July 1, 1990, applies to this case. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, "the litigation savings clause" contained in Oregon Laws 1990 (Special Session), Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., Oregon Laws 1990 (Special Session), ch 2, Section 54(3). Moreover, the act applies retroactively unless it would be absurd or unjust. See Coble v. T.W. Kraus & Sons, 116 Or App 62 (1992); Ida M. Walker, 43 Van Natta 1402 (1991). Here, it would not be absurd or unjust. See, e.g., Thomas Lundy, 43 Van Natta 2307 (1991). Therefore, we agree with the employer's contention that the law should be applied retroactively.

Temporary Disability Benefits

The employer closed claimant's claim on October 8, 1992. A January 27, 1993 Order on Reconsideration awarded claimant substantive temporary disability. The employer requested a hearing and claimant's substantive entitlement to temporary disability was settled by the May 18, 1993 stipulation, in which the parties agreed that all issues raised or which could have been raised were settled by the stipulation. Such a stipulation is a final "judgment." See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). Thus, insofar as the employer seeks to reduce claimant's temporary disability benefits below what was awarded by the Order on Reconsideration and Stipulation, it is precluded by the final judgment on this issue. Furthermore, insofar as claimant seeks additional procedural temporary disability, we are precluded from awarding more than claimant's substantive entitlement under the Order on Reconsideration and Stipulation. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Penalties and Attorney Fees for Failure to Pay Temporary Disability

However, even though claimant's substantive right to temporary disability compensation was settled by the Order on Reconsideration and Stipulation, the employer's obligation to pay procedural temporary disability benefits must be considered for penalty purposes. Lebanon Plywood v. Seiber, supra. As noted above, we apply the Workers' Compensation Act as amended in 1990 to our analysis of the procedural temporary disability issue.

Under the Workers' Compensation Act as amended July 1, 1990, the employer could terminate claimant's procedural temporary total disability benefits based on the attending physician's release to regular or modified work, even if claimant was not medically stationary. ORS 656.268(3). Here, claimant's attending physician indicated that claimant was released for full time work without limitation effective November 12, 1987. (Exs. 16 and 38-4). Consequently, we conclude that claimant was entitled to procedural temporary disability benefits from September 4, 1987 until November 12, 1987, subject to offset for any unemployment benefits, temporary disability, or wages received.

The employer timely paid temporary total disability from September 4, 1987 to September 18, 1987 in response to the February 18, 1988 Stipulation Order, but unilaterally terminated temporary disability payments subsequent to that time without lawful authority to do so. We conclude that the unilateral termination was unreasonable. Consequently, claimant would be entitled to a penalty up to 25 percent of the "amounts then due" for the employer's unreasonable refusal to pay compensation.

These temporary disability amounts were paid on December 12, 1990. Thus, the penalty basis for the employer's unreasonable refusal to pay compensation would include the compensation that was due but unpaid (temporary disability from September 19, 1987 to November 12, 1987) during the delay period from September 19, 1987 until December 12, 1990, when the unreasonable conduct was rectified. See Pascual Zaragoza, 45 Van Natta 1221 (1993); Jeffrey D. Dennis, 43 Van Natta 857 (1991). However, inasmuch as the maximum 25 percent penalty has already been assessed pursuant to our 1990 order (see below) on this, the only compensation due, no additional penalty is allowed. See Jeffrey D. Dennis, supra; Kim L. Haragan, 42 Van Natta 311, 313 (1990); Rob Cohen, 39 Van Natta 649, 652 (1987).

However, claimant's attorney is entitled to a reasonable assessed attorney fee, whether or not there are "amounts then due" so long as there is "unreasonable resistance to the payment of compensation" under ORS 656.382(1). Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989); Lloyd C. Cripe, 41 Van Natta 1774 (1991). Inasmuch as we have concluded that the employer's unilateral termination of temporary disability payments was unreasonable resistance to the payment of compensation, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that an assessed fee of $500 is appropriate.

Penalty and Attorney Fees Pursuant to the Board's 1990 Order

The employer was ordered by the Board to pay a penalty for its unreasonable partial denial equal to 25 percent of compensation due claimant at the time of the hearing before the prior referee, which we have here decided is compensation from September 4, 1987 to November 12, 1987. Claimant is now entitled to that penalty, offset by the employer's previous payment of the penalty for the period of time between September 19, 1987 and December 1, 1987. The employer was also ordered to pay a penalty-related assessed fee of $300 to claimant's attorney, which is also offset by the employer's previous payment. (See Claimant's Opening Argument at 3). We agree with the Referee that claimant is not entitled to an additional penalty and related attorney fee pursuant to ORS 656.262(10)(a) for failure to pay the penalty and attorney fee, as neither a penalty nor attorney fee is considered to be compensation. Benjamin G. Parker, 42 Van Natta 2476 (1990).

Interest

We adopt and affirm the Referee's opinion on this issue.

Assessed Attorney Fee

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

ORDER

The Referee's order dated July 1, 1992, as reconsidered September 25, 1992, is affirmed in part and reversed in part. That portion of the order that assessed a penalty for the employer's allegedly unreasonable claim processing is reversed. Claimant is Claimant's attorney is awarded $500 for the employer's unreasonable resistance to the payment of compensation. The remainder of the order 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
JEFFREY M. FISHER, Claimant
WCB Case Nos. 93-01032 & 92-13756
ORDER ON REVIEW
Cummins, et al., Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Referee T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's (Coleman's Well Drilling) denial of claimant's aggravation claim for a right shoulder condition; and (2) upheld SAIF's (Treasure Line Woodworks) denial of claimant's occupational disease claim for the same condition. Claimant seeks admission of materials that are not part of the hearing record. We treat such a submission as a request for remand. Judy A. Britton, 37 Van Natta 1262 (1985). Claimant also objects to certain evidence included in the hearing record. On review, the issues are remand, evidence, compensability, and responsibility. We deny the motion to remand and reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's "Findings of Fact" as supplemented by the following ultimate findings.

The record in this case was not improperly, incompletely or otherwise insufficiently developed or heard by the Referee.

Claimant has experienced right shoulder symptoms on a routine basis since his initial injury with Coleman's Well Drilling (Coleman's) in 1990. Claimant's current right shoulder symptoms are attributable to a pathological condition.

Claimant's 1990 injury with Coleman's is a material contributing cause of his current right shoulder pathology. Claimant's current condition is not due in major part to an off-work injury or activity.

Claimant's work with Treasure Line Woodworks (Treasure Line) did not independently contribute to a pathological worsening of claimant's condition. Nor is it the major contributing cause of his current condition.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand a case for additional evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). To merit remand, the moving party must establish that the evidence was not obtainable with due diligence at the time of hearing and that it was reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still be "obtainable" at the time of hearing. Id. at 648; James E. Gore, 45 Van Natta 1652 (1993).

Here, claimant seeks admission of the following materials that are not included in the hearing record: evidence in support of claimant's credibility; a safety citation filed against Treasure Line; evidence of a pre-hearing settlement offer made by SAIF; and an additional medical opinion diagnosing claimant's condition, including post-hearing surgery reports. We consider the proferred evidence only to determine whether remand is appropriate.

Consideration of the new materials submitted on review would not effect the outcome of this case. Compton v. Weyerhaeuser Co., supra; Maximino Martinez, 45 Van Natta 1143 (1993). We note, in particular, that the outcome would be the same with or without additional diagnostic information. Although claimant's treating physicians have not arrived at a definitive diagnosis, their opinions establish that claimant suffers from a genuine pathological condition. Weiland v. SAIF, 62 Or App 810 (1983). (Exs. 15, 16, 21A and 24). A definitive diagnosis of that pathology is not required to establish compensability and assign responsibility. Boeing Aircraft Co. v. Roy, 112 Or App 10 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

Moreover, with the exception of the post-hearing surgery reports, the materials submitted on review were available or obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., supra; James E. Gore, supra; Maximino Martinez, supra. We reach this conclusion notwithstanding claimant's argument that he was not informed prior to hearing that his credibility would be in issue, and that his former attorney did not otherwise effectively represent him at hearing.

Credibility is always potentially an issue in a compensability case. Claimant's burden of establishing compensability included a duty to rebut any challenges to his credibility. Furthermore, it is clear from SAIF's cross-examination at hearing that it was challenging claimant's credibility. Claimant had the opportunity at that time to present rebuttal evidence. Any failure to fully develop the record on this or any other issue is a matter between claimant and his former attorney. It is not a sufficient ground for remand. Gerald D. Bryan, 42 Van Natta 1159 (1990).

In summary, we conclude that the new materials offered on review would not affect the outcome of this case. We further conclude that, with the exception of the post-hearing surgery reports, the proferred materials were available or obtainable with due diligence at hearing. Accordingly, we conclude that this case has not been insufficiently developed, and we deny claimant's motion to remand. ORS 656.295(5).

Evidence

Claimant objects to certain evidence that is included in the hearing record. Specifically, claimant objects to SAIF's use of an investigative report in cross-examining claimant at hearing. Claimant contends that this report was not made available to him prior to hearing. Claimant also objects to the Referee's admission of Exhibit 25, which is Treasure Line's record of claimant's absences from work. The Referee relied on the latter report in concluding that claimant did not credibly testify regarding his symptomatic history. We decline claimant's request to exclude this evidence.

In regard to the investigative report, the transcript indicates that the Referee did limit its use pursuant to an objection by claimant's attorney. Claimant made no further objection to SAIF's use of that document in its cross-examination. Claimant also had the opportunity to object at hearing to the report of his work absences, but failed to do so. (Tr. 29-30, 33-34, 70). The failure to timely object to this evidence is a matter between claimant and his former attorney. It is not a sufficient ground for exclusion of the evidence on review. Cf. Gerald D. Bryan, supra.

Furthermore, excluding these reports from the record would not change our ultimate disposition of this case. In particular, we note that our assessment of claimant's credibility does not turn on the report of claimant's work absences. As discussed below, the record as a whole otherwise supports claimant's testimony regarding his symptomatic history.

Accordingly, we conclude that the report of claimant's work absences and SAIF's cross-examination using its investigative report would not change the outcome in this case. We further conclude that claimant has waived his right to object to this evidence by failing to make the appropriate objections at hearing. We, therefore, decline claimant's motion to exclude this evidence from the record. Cf. Compton v. Weyerhaeuser Co., supra.

Compensability/Responsibility

The Referee concluded that claimant had not established a compensable claim against either Coleman's or Treasure Line. On review, claimant contends that his current right shoulder condition is compensable as an aggravation of his accepted 1990 injury claim with Coleman's. To prevail on his aggravation claim, claimant must prove that his current condition is compensably related to the 1990 injury, and that the condition has worsened since the last arrangement of compensation. ORS 656.273(1).

The parties agree that claimant has sustained a compensable aggravation if his current condition is compensably related to the 1990 injury. To meet this burden, claimant must establish that his 1990 injury is a material contributing cause of his current condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-work injury or activity which is the major contributing cause of the condition, the aggravation claim is not compensable. ORS 656.273(1); Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Lucky L. Gay, 44 Van Natta 2172 (1992); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

The record contains relevant opinions on causation from Dr. Potter, claimant's former treating physician, and Dr. Donahoo, who conducted an examination in December 1992. Dr. Potter opined that claimant's right shoulder symptoms are secondary to use of a sander at Treasure Line, and are not secondary to the original injury with Coleman's. (Ex. 20). On the other hand, Dr. Donahoo opined that claimant's drilling activity with Coleman's was the major cause of his current condition. (Ex. 22).

Drs. Donahoo and Potter based their opinions on different symptomatic histories. Dr. Donahoo's opinion assumes the accuracy of the history given him by claimant of continuing symptoms since the 1990 injury with Coleman's. On the other hand, Dr. Potter assumed that claimant's symptoms had resolved when his claim with Coleman's was closed in June 1992. Dr. Potter based this history, in part, on the fact that claimant was doing well at his March 1992 closing examination. Dr. Potter also relied on claimant's October 1992 statement that he was not having shoulder problems when he left his employment with Coleman's in June 1992.

At hearing, claimant testified to the history of continuing symptoms relied on by Dr. Donahoo. (Tr. 10-11, 13-14, 22, 25, 34-38). The Referee found claimant not credible, reduced the weight given his testimony and was ultimately unable to determine which, if any, of the medical opinions was based on an accurate symptomatic history. Therefore, the Referee discounted both opinions and concluded that claimant had not established a compensable claim.

In reaching that decision, the Referee considered the demeanor of the respective witnesses, as well as inconsistencies in the documentary record. Despite the Referee's reference to demeanor, most of his reasoning concerning claimant's credibility pertains to inconsistencies in the record. In light of such circumstances, we conclude that the Referee's credibility finding was primarily based on the substance of the record rather than demeanor.

The Board is in as good a position as the Referee to make a credibility finding based on the substance of the record. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Based on our de novo review, we conclude that the record as a whole supports claimant's testimony of continuing symptoms. We reach this decision despite the fact that claimant apparently gave a different history to Dr. Potter in October 1992. However, claimant has otherwise consistently reported a history of continuing symptoms. As discussed above, claimant gave a history of continuing symptoms to Dr. Donahoo in December 1992. Claimant had previously given the same history to Dr. Kho in September 1992.

Furthermore, the medical record provides a clear historical trail leading back to claimant's 1990 injury with Coleman's. Claimant's current symptoms are of the same kind and in the same location as those he experienced during his employment with Coleman's. In particular, claimant continues to suffer from the same electric shock sensation in the shoulder, neck and arms which he reported in January 1992.

Moreover, the fact that claimant was doing well at Dr. Potter's March 1992 closing examination does not establish that his 1990 injury had resolved. At his closing examination, claimant continued to demonstrate a pathological abnormality in his right shoulder. (Ex. 13). Furthermore, at that time he had not returned to his former level of heavy activity. Claimant explained at hearing that his symptoms flared up when he subsequently returned to heavy work. Claimant also plausibly explained that he did not seek further medical treatment because he decided to control his symptoms by changing the type of work that he did.

Finally, we note that many of the inconsistencies in the record discussed by the Referee were related to collateral matters that are not directly relevant to the issues before the Board. In particular, the Referee relied on evidence that claimant had given false information to his employer regarding his absences from work, and the fact that claimant had given different explanations regarding why he was fired by Treasure Line. (Tr. 43, 48, 54, 58-59, 66, 74, 76-77). Inconsistent statements related to such collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports his testimony of continuing symptoms. See Peterson v. Eugene F. Burrill Lumber, 57 Or App 476, 480 (1992); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984).

In summary, we find that claimant has experienced right shoulder symptoms on a regular basis since his 1990 injury. Based on that history, Dr. Donahoo opined that claimant's work activity with Coleman's is the major contributing cause of his current right shoulder condition. We defer to Dr. Donahoo and conclude that the 1990 injury with Coleman's is, at least, a material contributing cause of claimant's current right shoulder condition.

Therefore, claimant's aggravation claim is compensable unless Coleman's can establish that claimant's condition is due in major part to an off-work injury or activity. ORS 656.273. Claimant's off-work activities clearly exacerbated his symptoms. (Ex. 12; Tr. 17-19, 21, 26, 28, 38-41, 78). However, there is no persuasive medical evidence that any off-work injury or activity is the major contributing cause of his worsened condition. Accordingly, claimant has established that his current right shoulder condition is compensable as an aggravation of his accepted 1990 injury with Coleman's. ORS 656.273(1).

Turning to the responsibility issue, we conclude that Coleman's remains responsible for claimant's condition. To avoid responsibility, Coleman's must prove that claimant sustained a new injury with Treasure Line, i.e., that the work with Treasure Line was the major contributing cause of claimant's resultant condition. ORS 656.308; SAIF v. Drews, 117 Or App 596 (1993). We have deferred above to Dr. Donahoo's opinion that the work with Coleman's, not Treasure Line, was the major cause of claimant's condition. Accordingly, Coleman's is responsible for claimant's current condition.

Claimant was represented by counsel at hearing and is entitled to an assessed attorney fee for ultimately 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 concerning the compensability issue is $1,OOO, to be paid by SAIF (Coleman's). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 28, 1993, as reconsidered July 23, 1993, is affirmed in part and reversed in part. The SAIF Corporation's (Coleman's) denial is set aside and the claim is remanded to SAIF (Coleman's) for further processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing, claimant's attorney is awarded $1,000, payable by SAIF (Coleman's).

In the Matter of the Compensation of
RONALD L. HANNOLD, Claimant
WCB Case No. 93-04708
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Neal's order which upheld the SAIF Corporation's denial of his occupational disease claim for a bilateral wrist condition and left carpal tunnel syndrome. 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.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded, based on the majority of medical opinion, that claimant failed to prove his occupational disease claim. We disagree with regard to claimant's left wrist condition.

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

Claimant testified that, in his work as a DEQ vehicle emissions inspector, he used his left hand primarily to release and lift vehicle hoods, and to screw gas caps. (Tr. 8-9, 16-18, 24, 33-34; see also Ex. 1). He performed inspection duties 4 hours per day, alternating with recording duties on an hourly basis. (Tr. 5). He explained that his wrist and hand symptoms came on gradually over the year prior to his initial treatment in January 1993, with left hand symptoms worse than the right. (Ex. 2; Tr. 4). Claimant, who is right-hand dominant, had no significant off-work activities involving use of his left hand. (Ex. 11-2; Tr. 6-8).

Considering the nature of claimant's work and the gradual onset of his wrist problems, we conclude that whether his work activities were the major contributing cause of his condition is a complex medical question, the resolution of which largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 240 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Only two doctors offered opinions on causation of the left wrist condition. Dr. Soldevilla, claimant's treating neurosurgeon who performed the carpal tunnel surgery, opined:

> "I can only state without equivocation that [claimant's] left carpal tunnel was due to his work activities, mainly releasing the latches on hoods with his left hand.* * * While there is no doubt that he is right-handed, but I believe that the reason that his right hand was not more symptomatic than his left was simply the way that he performs his duties."

(Ex. 15). He offered this opinion after performing claimant's surgery and after reviewing the reports of examining physicians Dr. Fuller and Dr. R. Rosenbaum.

Dr. Fuller, an orthopedist who examined claimant at SAIF's request, believed it unlikely that claimant's work activities caused his left carpal tunnel condition. (Ex. 11-4 to -5). However, he concluded that the etiology of claimant's left wrist condition "will not be fully explained until an exploration of the left carpal canal is performed." (Ex. 11-4). Dr. Rosenbaum performed a record review for SAIF, but he did not offer an opinion regarding causation. (Ex. 8-2).

When medical evidence is divided, we generally defer to the treating doctor, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find none in this case. Moreover, Dr. Fuller also deferred to the operating physician's opinion, conceding that the etiology of claimant's left wrist condition would not be fully explained until the left carpal canal is explored. (Ex. 11-4).

Accordingly, we conclude that claimant has established, by a preponderance of the evidence, that work activities were the major contributing cause of his left wrist condition. In addition, we find that claimant established his left wrist condition by medical evidence supported by objective findings. (See Exs. 5, 6, 7). Therefore, we conclude that claimant has established the compensability of an occupational disease claim for his left wrist condition.

However, we find that claimant has failed to establish the compensability of his occupational disease claim for a right wrist condition. Only Dr. Breen diagnosed "bilateral wrist strain" upon his initial treatment of claimant in January 1993. (Ex. 2). Subsequent diagnostic tests revealed a normal right hand. (Exs. 3, 5, 6). Subsequently, Dr. Breen diagnosed and treated only claimant's left carpal tunnel condition. (See Exs. 7, 13). Claimant admits that he did not receive treatment for his right wrist. (Tr. 14, 20-21). Under these circumstances, we conclude that claimant failed to establish, by medical evidence supported by objective findings, the existence of a right wrist strain. ORS 656.802(2). Accordingly, we uphold SAIF's denial with respect to claimant's right wrist condition.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue regarding the left wrist. 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 left wrist condition is $2,700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 20, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the SAIF Corporation's denial of left carpal tunnel syndrome is reversed. The denial of claimant's left wrist condition is set aside, and that claim is remanded to SAIF for processing in accordance with law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $2,700 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
GINA M. McDONALD, Claimant
WCB Case Nos. 92-08952, 92-08306 & 92-06014
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
H. Thomas Anderson (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Black's order that: (1) concluded that Liberty's acceptance of claimant's 1988 injury claim for right hand tendonitis included claimant's current right carpal tunnel syndrome (CTS); (2) set aside Liberty's denial of the compensability of and responsibility for claimant's occupational disease claim for right CTS; (3) upheld the SAIF Corporation's "de facto" denial regarding the same condition on behalf of Jeff Kemp; (4) upheld SAIF's "de facto" denial regarding the same condition on behalf of Diane's Preschool and Day Care; (5) upheld SAIF's denial regarding the same condition issued on behalf of Rogue River Enterprises, Inc.; and (6) upheld SAIF's denial regarding the same condition as processing agent for Lois Whitehead Real Estate. On review, the issues are compensability, scope of acceptance, and responsibility. We affirm.

FINDINGS OF FACT

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

Claimant began working for Gold Beach Plywood, Inc. (Gold Beach), Liberty's insured, in April 1986. For the next 2 months, she worked for Gold Beach as a skoog operator, a position that was arm and hand intensive, particularly on the right.

On February 2, 1988, while employed at Gold Beach, claimant experienced shooting pain in her right wrist. On February 5, 1988, claimant consulted Dr. Taylor, osteopath, who diagnosed "pain right hand, most likely tendinitis." (Ex. 1-1). Thereafter, Dr. Taylor diagnosed tendinitis of the right hand, right hand and wrist pain, and overuse, right hand. (Id. at 2, 3).

Dr. Taylor referred claimant to Dr. Bernstein, neurologist. Dr. Bernstein diagnosed probable myofacial syndrome, and noted that, although claimant's nerve conduction studies were normal at the time, claimant's symptoms were suggestive of CTS. (Ex. 4-3). In turn, Dr. Bernstein referred claimant to Dr. Adams, orthopedic surgeon, who diagnosed industrial wrist syndrome of undetermined etiology. (Ex. 5-2). Dr. Adams also noted that claimant might have CTS. (Id.)

On April 15, 1988, Liberty accepted a claim for "tendonitis, right hand." (Ex. 7). A week later, on April 22, 1988, Dr. Adams reported that claimant had mild, asymptomatic CTS. (Ex. 8). Claimant's claim was closed on June 17, 1988 by a Determination Order that awarded her temporary total and partial disability. (Ex. 9).

Claimant left her position with Gold Beach in February 1988. Thereafter, she worked for Jeff Kemp, tax consultant, as a secretary-receptionist; for Diane's Preschool and Day Care as a preschool teacher;[1] and for Lois Whitehead Real Estate (Lois Whitehead), where she performed clerical duties and assisted clients. (Ex. 23). In November 1990, claimant began her current employment with Rogue River Enterprises, Inc. (Rogue River), a center for developmentally disabled adults. (Id. at 2). Claimant's job title was activity supervisor, and her duties included assisting clients with art projects, supervision and attending meetings. (Id.) SAIF is the insurer or claim processor for each of claimant's post-Gold Beach employers.[2]

After claimant left Gold Beach, she continued to have intermittent right wrist pain, along with increasing numbness in the fingers of her right hand. (Ex. 10-1). In November 1991, claimant dropped a gallon of milk, which prompted her to again seek medical treatment for her right wrist condition.

On November 18, 1991, Dr. Bernstein conducted nerve conduction studies that revealed that claimant had moderate to markedly severe right CTS. (Id. at 3, 5). Thereafter, Dr. Adams requested authorization to perform a right carpal tunnel release. (Ex. 13). Adams performed the surgery on February 6, 1992. (Ex. 15).

Thereafter, Liberty denied the compensability of and responsibility for claimant's right CTS. (Ex. 16). SAIF subsequently denied the compensability of and responsibility for the claim on behalf of Rogue River and Lois Whitehead. (Exs. 17, 20A, 22). With respect to Jeff Kemp and Diane's Preschool and Day Care, the claim was denied "de facto."[3]

FINDINGS OF ULTIMATE FACT

Claimant's work exposure at Gold Beach was the major contributing cause of her right CTS.

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[1] Claimant was also employed by Checkmate Accounting for two months in 1989. (See Ex. 23-2). Checkmate Accounting is not a party to these proceedings.

[2] Lois Whitehead was determined to be a noncomplying employer. (Exs. 19, 20). SAIF was requested to process claimant's right CTS claim on Lois Whitehead's behalf. (Ex. 19).

[3] At hearing, claimant's counsel stated that SAIF's counsel was prepared to orally deny the claim on behalf of Jeff Kemp and Diane's Preschool and Day Care. (Tr. 5). However, SAIF's counsel stated that he was "not confirming that we deny on behalf of those employers that [claimant's] condition is compensable as to them." (Tr. 6).

CONCLUSIONS OF LAW AND OPINION

Compensability

Because the evidence reveals that the symptoms that culminated in claimant's current condition had a gradual onset, we analyze that condition as an occupational disease. See Valtinson v. SAIF, 56 Or App 186 (1982).[4] To prove a compensable occupational disease, claimant must prove that her work activities were the major contributing cause of the onset or worsening of her right CTS. ORS 656.802(2); see Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991). "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Enid S. Crowe, 45 Van Natta 1718 (1993).

Four physicians rendered reports regarding the cause of claimant's right CTS. Dr. Adams, claimant's treating surgeon, concluded that, because claimant had not done any other work than that for Gold Beach from 1986 through 1988, her CTS was related to her industrial repetitive activities. Because Dr. Adams' report inaccurately reflects claimant's post-Gold Beach work history, we discount his opinion. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Jewell, neurologist, rendered a report on behalf of Liberty, and concluded that he could not state with reasonable medical probability that claimant's right CTS was the result of her work exposure at Gold Beach. (Ex. 14-3). Dr. Jewell stated that if claimant had an overuse problem, he would have expected her condition to resolve on its own, without residual, following her cessation of employment with Gold Beach. (Ex. 14-3). In light of claimant's negative nerve conduction studies in 1988, Dr. Jewell concluded that claimant's current condition was related to "other factors." (Id.)

We find Dr. Jewell's opinion unpersuasive for several reasons. First, although he took into account claimant's most recent work history with Rogue River, and he noted that claimant's current employment did not require hand-intensive work, Dr. Jewell did not discuss claimant's other post-Gold Beach employments. See Somers v. SAIF, supra. Second, Dr. Jewell did not adequately explain the "other factors" to which claimant's right CTS was supposedly related. Finally, as discussed below, we find more persuasive Drs. Woolpert's and Bernstein's analyses regarding the onset of claimant's symptoms and positive nerve conduction studies in 1991. For these reasons, we do not rely on Dr. Jewell's opinion.

The next opinion we consider is that of Dr. Woolpert, orthopedic surgeon, who examined claimant on SAIF's behalf. (Ex. 18A). Dr. Woolpert specifically reported that he found claimant to be reliable. (Id. at 4). After obtaining an extensive history, Dr. Woolpert concluded that, although claimant's current symptoms began after she left Gold Beach's employ, she had intermittent but continued numbness, tingling and discomfort in her right wrist up until she had her carpal tunnel release in February 1992. (Id.)

Dr. Woolpert found very important the continuity of claimant's symptoms. (Id.) He also found important the fact that claimant's post-Gold Beach work responsibilities did not involve repetitive work and usually were the type to aggravate CTS. (Id.) Dr. Woolpert concluded that, although claimant did not definitively have CTS in 1988, and although her subsequent employment may have caused some

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[4] At hearing, claimant litigated this matter as both a resultant condition and an occupational disease claim. (See Tr. 10). On review, claimant argues that this case should be analyzed as an aggravation claim. We disagree. In the first place, claimant's requests for hearing specified the issues as compensability and responsibility, not aggravation.

In any event, to establish an aggravation claim, claimant must prove that her current condition is compensably related to her original work injury and that the compensable condition has worsened since the last arrangement of compensation. ORS 656.273(1); see also Gray v. SAIF, 121 Or App 217 (1993).

None of the medical evidence relates her current condition to her original work injury. Based on our review of the medical evidence, we conclude that the persuasive evidence relates her current condition to her employment exposure at Gold Beach. Accordingly, we treat this as an occupational disease claim.

worsening of her CTS, in light of her continued symptoms, the major cause of her CTS probably was her employment duties at Gold Beach. (Id. at 5).[5]

Lastly, Dr. Bernstein, claimant's consulting neurologist, concurred with a letter written by claimant's counsel, agreeing that, in light of a detailed and accurate employment history, the major contributing cause of claimant's right CTS was her employment activities with Gold Beach. (Ex. 23). Bernstein agreed that it was not uncommon for people to have normal nerve conduction studies just as they begin to develop CTS. He believed that that is what happened with claimant: Her CTS began in 1988, but had not sufficiently developed to manifest itself on nerve conduction studies at that time. (See id. at 3). Finally, Dr. Bernstein agreed that, although claimant's work activities subsequent to her employment at Gold Beach could have materially contributed to the worsening of her CTS, her Gold Beach employment remained the major cause of that condition. (Id.)

We find the opinions of both Drs. Woolpert and Bernstein persuasive. Both opinions are based on extensive work histories. Moreover, both persuasively address the relative contribution of claimant's post-Gold Beach employment activities to her current condition, concluding that those activities could have been a material, but not a major, contributing factor in claimant's right CTS. We find particularly compelling Dr. Woolpert's emphasis of the continuing nature of claimant's symptoms, see SAIF v. Luhrs, 63 Or App 78 (1983), and the fact that Dr. Bernstein had the opportunity to examine claimant in both 1988, shortly after her original work injury, and in 1991, after the onset of the symptoms of her right CTS.

For these reasons, we conclude that claimant has established that her right CTS is a compensable occupational disease. See ORS 656.802(2).

Scope of Acceptance/Responsibility

The Referee found that, by accepting claimant's 1988 "right hand tendonitis", Liberty also accepted claimant's current right CTS condition. Accordingly, the Referee concluded that, under ORS 656.308(1), Liberty remains the responsible employer. We agree with the Referee's conclusion; however, we offer the following analysis.

A carrier's acceptance of a claim includes only those injuries or conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Here, Liberty specifically accepted "tendonitis, right hand" in 1988. (Ex. 7). Although there is some evidence that claimant had early CTS in 1988, there is no evidence that claimant's 1988 tendonitis claim included CTS. Accordingly, we conclude that Liberty's 1988 acceptance did not include claimant's current right CTS. See Mary H. Morris, 44 Van Natta 1273 (1992).[6]

Because there is no prior accepted claim for claimant's CTS, a determination must be made concerning the assignment of initial responsibility for that condition. Accordingly, ORS 656.308(1) is not applicable. See Fred A. Nutter, 44 Van Natta 854 (1992).

Ordinarily, when there is no prior accepted claim for a claimant's condition, we turn to the last injurious exposure rule to determine who, among several employers, is initially responsible. See, e.g., Bracke v. Baza'r, 293 Or 239 (1982). When, however, actual causation is proved with respect to a specific employer, the last injurious exposure is not applied. Eva R. Billings, 45 Van Natta 2142 (1993); see Runft v. SAIF, 303 Or 493 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

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[5] Dr. Woolpert's opinion actually states that "I would feel that probably the major causative factor [of claimant's current condition] would be a pre-existing condition which had never resolved while working for Gold Beach. This would be the major need for surgical treatment." (Ex. 18A-5). In view of Dr. Woolpert's conclusion that claimant has right CTS and that she did not have any problems that preexisted her employment at Gold Beach, (id. at 4), we construe Dr. Woolpert's opinion to mean that the major contributing cause of claimant's right CTS was her employment exposure at Gold Beach.

[6] Claimant also argues that Liberty's acceptance of claimant's right hand tendonitis does not comply with ORS 656.262(6) and, therefore, is not determinative of the scope of Liberty's acceptance. Because claimant did not raise that argument at hearing, we will not consider it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Here, as we discussed in detail earlier, the persuasive medical evidence establishes actual causation with respect to Gold Beach, Liberty's insured. (See Exs. 18A, 23). Accordingly, we do not apply the last injurious exposure rule. Eva R. Billings, supra.

For the above reasons, we conclude that the preponderance of the evidence establishes that the major contributing cause of claimant's right CTS was her work exposure at Gold Beach. Accordingly, Liberty, as Gold Beach's insurer, is responsible.

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to this 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 May 28, 1993, is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
JOHN P. ROBINSON, Claimant
WCB Case No. 92-06258
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Barber's order which: (1) excluded two letters (Exhibits 9A and 9B) at hearing; and (2) found that claimant was barred by the doctrine of res judicata from litigating the compensability of his claim for carpal tunnel syndrome. On review, the issues are evidence, the preclusive effect of a stipulation on the claim for carpal tunnel syndrome and, if claimant is not precluded, compensability . We affirm.

FINDINGS OF FACT

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

On February 28, 1991, claimant filed a claim for right carpal tunnel, which the employer denied on May 10, 1991. In relevant part the denial stated:

> "On February 28, 1991, you filed a workers' compensation claim alleging a right carpal tunnel syndrome.
>
> "Our investigation of this claim has been completed and this letter is to inform you that we will be unable to accept your claim. The medical evidence indicates that you do not have a carpal tunnel syndrome nor tenosynovitis of the right wrist."

Claimant requested a hearing contesting the employer's denial. By letter dated November 8, 1991, the employer notified claimant that it had "received and accepted [his] claim for disabling resolved bilateral wrist tendonitis."

A November 29, 1991 Determination Order closed the claim without an award of permanent disability. That order was subsequently affirmed by an April 24, 1992 Order on Reconsideration.

Meanwhile, on February 28, 1992, Referee Hoguet approved a stipulation which resolved claimant's pending hearing request regarding the employer's denial of claimant's right wrist carpal tunnel syndrome or tendonitis. The stipulation provided in relevant part:

"Claimant alleged to have had an occupational disease that occurred on or about February 21, 1991. A claim was made, investigated by the employer, and subsequently denied by the denial letter of May 10, 1991. The claimant, through his attorney, appealed from this denial in a timely fashion.

"Prior to hearing, parties have agreed to settle this matter upon the following terms and conditions:

"A. The employer will accept a condition diagnosed as a right wrist tendinitis. That condition has been accepted by the insurance representative even prior to this stipulation.

"B. Claimant's attorney is entitled to reasonable attorney fees in the amount $750.00 for his assistance to the claimant.

"C. The parties agree that this settles all issues raisable and claimant's current request for hearing, and the request for hearing may be dismissed with prejudice."

On April 30, 1992, claimant requested a hearing regarding the April 24, 1992 Order on Reconsideration. In addition, claimant raised the issue of a "de facto" denial of bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

Claimant contends that the Referee improperly excluded letters prepared by counsel, which would have clarified the ambiguous terms of the settlement stipulation as to the scope of the employer's actual acceptance.

The Referee excluded the letters on the ground that they were privileged information as part of the negotiation process and that he could not use the letters to go behind the terms of a signed stipulation. (Tr. 12-14). Based on our conclusion below, we need not resolve this evidentiary question.

Res Judicata

The Referee concluded that, under the res judicata doctrine of claim preclusion, claimant was precluded from litigating the compensability of his carpal tunnel syndrome condition. The Referee relied on the terms of the February 28, 1992 settlement stipulation. We agree.

Essentially, a party may not relitigate any issue resolved by a stipulation or DCS, since a party is bound by such agreement. Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993); Gilkey v. SAIF, 113 Or App 314, 316-17 (1992); International Paper Co. v. Pearson, 106 Or App 121, 124 (1991); Proctor v. SAIF, 68 Or App 333, 335 (1984). See Southwest Forest Industries v. Archer, 109 Or App 349 (1991); Wassen v. Evanite Fiber Corp., 117 Or App 246, 248 (1992). Cf. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). Consequently, we look only to the terms of the agreement to determine whether a party is precluded from litigating a particular issue. Furthermore, where the settlement stipulation is unambiguous and resolves all issues raised or raisable, the relevant inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement. Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994).

In Stoddard, the court found that a prior unambiguous stipulation concerning the closure of an accepted wrist claim precluded the claimant from subsequently asserting the compensability of a radial nerve condition/surgery. The stipulation provided that the wrist claim would remain in closed status "with all issues which were raised or which could have been raised" by the date of the stipulation's approval "having been resolved with prejudice." Although the claimant's physician had diagnosed the nerve condition and recommended treatment at the time of the stipulation, the Board reasoned that the claimant had not intended to waive her right to claim compensability of that condition. Concluding that the nerve condition was causally related to to the accepted wrist injury, the Board held that the nerve condition was compensable.

Citing Safeway Stores, Inc. v. Seney, supra, the court identified the correct inquiry as whether the claimant's condition and its compensability could have been negotiated before approval of the stipulation. Inasmuch as the nerve condition had been diagnosed and the medical services requested at the time of approval of the stipulation, the court determined that the nerve condition was an issue that could have been raised before the approved stipulation. Consequently, the court held that the nerve claim was barred.

Here, the parties' unambiguous stipulation provided for the settlement of "all issues raisable and claimant's current request for hearing, and the request for hearing may be dismissed with prejudice." The stipulation resolved all issues, including issues raised via claimant's appeal of the May 1991 denial, that related to claimant's February 1991 occupational disease claim. Claimant's condition had been variously diagnosed as tendonitis and early carpal tunnel syndrome and medical services had been provided. The employer issued a denial of both the tendonitis and carpal tunnel syndrome. In November 1991, the employer accepted the claim for tendonitis only. Thus, the compensability of claimant's carpal tunnel syndrome was at issue before approval of the settlement stipulation.[1]

Since the compensability of the claim for carpal tunnel syndrome was an issue raised, the stipulation resolved that claim when all other issues were dismissed with prejudice. See Safeway Stores, Inc. v. Seney, supra; Good Samaritan Hospital v. Stoddard, supra. We, therefore, conclude that claimant is precluded by the stipulation from litigating the compensability of his claim for carpal tunnel syndrome.

ORDER

The Referee's order dated April 5, 1993 is affirmed.

[1] We also note that more than three months prior to the stipulation, the employer had issued a notice of acceptance for bilateral wrist tendonitis. Claimant did not challenge the scope of the acceptance until his April 1992 request for hearing appealing the Order on Reconsideration.

In the Matter of the Compensation of
JOYCE E. SOPER, Claimant
WCB Case No. 93-03308
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Davis' order which: (1) upheld the SAIF Corporation's denial of claimant's current bilateral thumb conditions; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant's current condition is the same condition that a prior referee found compensable.

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on ORS 656.005(7)(a)(B), the Referee found that the major cause of claimant's current condition was her preexisting arthritic condition. Therefore, the Referee upheld SAIF's denial of that condition. We disagree with the Referee's analysis for the following reasons.

At the outset, we note that ORS 656.005(7)(a)(B) is not applicable. Claimant's degenerative arthritis condition was ordered accepted by a prior referee's order as a compensable occupational disease. Thus, there is no preexisting disease; only a compensable occupational disease which SAIF was previously ordered to accept. Moreover, there is no evidence that the compensable arthritic condition combined with any other preexisting disease. Accordingly, we do not decide this case based on ORS 656.005(7)(a)(B). See Lizbeth Meeker, 44 Van Natta 2069, 2071 (1992). Rather, we find that the insurer is precluded from denying claimant's degenerative arthritis 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 1991, Dr. Cutler, hand surgeon, diagnosed bilateral degenerative arthritis, trapezometacarpal joints in claimant's thumbs. (Ex. 2). In September 1991, the SAIF Corporation denied bilateral degenerative arthritis. By Opinion and Order dated March 6, 1992, a referee set aside SAIF's denial of claimant's occupational disease claim for "worsened bilateral degenerative arthritis of the hands." (Emphasis added). (Ex. 7-3). Claimant's claim was closed by Notice of Closure in January 1993, with no award for permanent disability.

In February 1993, claimant returned to Dr. Cutler. Dr. Cutler noted that conservative treatment of claimant's accepted condition had not been successful, and again recommended a trapezo metacarpal arthroplasty of the right thumb. (Ex. 12). Dr. Cutler had previously recommended surgery in July 1991 if proposed steroid injections were not effective. (Ex. 4).

SAIF denied claimant's current condition claim, stating that "the temporary worsening accepted by SAIF Corporation has resolved with no impairment" and that claimant's preexisting degenerative disease was the major contributing cause of the current condition. (Ex. 13).

In light of Dr. Cutler's opinion, we are persuaded that claimant's current condition is the same condition that was found compensable by the earlier referee order. That order was not appealed to the Board. Thus, under the doctrine of issue preclusion, the March 6, 1992 Opinion and Order establishes as a matter of law that claimant's degenerative arthritis condition is compensable. Therefore, SAIF is precluded from subsequently denying that same condition. Inasmuch as SAIF's denial is based on the premise that claimant's degenerative arthritis 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).

Penalties and Attorney Fees

Claimant seeks a penalty under ORS 656.262(10) for an allegedly unreasonable denial of her current bilateral thumb condition. A penalty for unreasonable denial may be assessed against an insurer or self-insured employer for unreasonable delay or refusal to pay compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time of SAIF's denial, a medical report from Dr. Cutler, claimant's treating physician, stated that claimant's work exposure was approximately 30 percent responsible for claimant's possible need for surgery. (Ex. 8-2). Further, a report from examining physician, Dr. Sultany, stated that claimant's preexisting osteoarthritis of the thumbs was the major cause of claimant's need for treatment. (Ex. 9-2). Accordingly, we find that SAIF's reliance on ORS 656.005(7)(a)(B) in finding that claimant's work exposure was not the major contributing cause of her current condition was a reasonable basis for its denial, and a penalty is not warranted under these circumstances.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's current thumb condition is $3,150, 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 appellant's brief and reply brief, claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved. No attorney fee is awarded for those portions of claimant's counsel's services devoted to the penalty issue.

ORDER

The Referee's order dated July 12, 1993 is reversed in part and affirmed in part. That portion of the order which upheld the SAIF Corporation's denial of claimant's current thumb condition is reversed. SAIF's 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 fee of $3,150, to be paid by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
TAMMY M. TALLMON, Claimant
WCB Case No. 92-12581
ORDER ON REVIEW
Russell E. Vause, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Hazelett's order that declined to find premature a Determination Order closing her cervical spine and bilateral ear injury claim without an award of permanent disability. On review, the issues are premature closure and extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

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

Dr. Epley, claimant's attending physician, performed a third surgery on claimant's right middle ear on February 17, 1992. He examined claimant and performed vestibular testing on April 10, 1992, noting residual dysfunction. Additional testing at the Oregon Health Sciences University on April 13, 1992 confirmed continuing balance problems and vestibular dysfunction.

When Dr. Epley reexamined claimant on April 20, 1992, she was functioning at 70 percent of normal. On a scale of 0 to 10 (with 10 the worst), claimant was at 10 for vertigo, at 10 for imbalance, at 9 for nausea, at 9 for ear pain, and at 10 for tinnitus. Epley advised claimant to attempt light duty work. The doctor concluded that claimant would require further treatment if either she did not improve or she worsened with light duty work. Finally, Dr. Epley instructed claimant to return in three months for reevaluation.

On May 12, 1992, and again on July 12, 1992, the employer received completed Supplemental Medical Report Forms from Dr. Epley. The doctor noted that when claimant was last examined on April 20, 1992, she was released for a trial of modified work. Dr. Epley further indicated that claimant was not yet medically stationary.

On July 14, 1992, the employer sent the following to claimant:

"According to our records, you have not received any medical treatment since 4/20/92 for [your compensable] injury. Your claim cannot be held in an open status indefinitely.

> "If you are still in need of medical treatment, you should tell your supervisor and report to your doctor at once so he/she can furnish us with a current report on your condition.
>
> "If we have not heard from your doctor within two weeks from the date of this letter, we will assume you have completely recovered from your injury without disability and proceed to have your claim closed."

The employer did not send a copy to claimant's attorney.

On the same date, the employer sent a letter to Dr. Epley, seeking clarification of claimant's medically stationary status. The employer did not send a copy to claimant's attorney.

Dr. Epley responded by forwarding a narrative report and copies of his April 20, 1992 exam findings. Dr. Epley explained that claimant still had active vertigo and tinnitus, and that as of April 20, 1992, he was still evaluating whether claimant's condition would improve with the passage of time or require additional surgery. The employer received Dr. Epley's report and chartnotes on August 14, 1992.

The employer sought administrative claim closure from the Department. On August 21, 1992, when contacted by the Department, the employer indicated that it had received no response to its "two-week letter." The employer did not submit Dr. Epley's latest reports to the Department. Thereafter, a Determination Order issued on August 27, 1992, finding claimant medically stationary on August 7, 1992, and administratively closing the claim with no award of permanent disability.

On September 4, 1992, Dr. Epley sent another Supplemental Medical Report Form to the employer, which it received on September 9, 1992. The doctor indicated that he had reexamined claimant on August 20, 1992, and that claimant was released for modified work on September 4, 1992. Dr. Epley also informed the employer that claimant had permanent right labyrinth dysfunction. The employer did not submit Dr. Epley's report to the Appellate Unit. Finding that claimant was last treated on April 20, 1992, and that no subsequent medical evidence had been presented, the Appellate Unit issued an Order on Reconsideration on September 16, 1992, affirming the Determination Order in all respects.

At hearing, claimant identified the issue as overturning the premature Determination Order so that her permanent restrictions could be rated (Tr. 8).

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The employer sought and was granted administrative claim closure by the Department pursuant to OAR 436-30-035. Former OAR 436-30-035(7) (WCD Admin. Order 5-1992) provides that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, provided that the insurer has notified the worker that claim closure would occur due to the worker's failure to seek medical treatment. In his order, the Referee declined to address the parties' arguments concerning the applicability of the rule, and instead reviewed the medical reports and concluded that claimant was medically stationary at the time of claim closure.

On review, claimant continues to challenge the applicability of former OAR 436-30-035 to close her claim. The employer, on the other hand, argues that the record as a whole supports the conclusion that there was no reasonable expectation of improvement with further treatment as of the administrative closure date. We conclude that the claim was prematurely closed.

Subsequent to the Referee's decision, the court noted that the initial issue to be addressed in administrative closure cases is whether the notice given claimant by an insurer was adequate for claim closure under OAR 436-30-035. Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993). Because the Board reviewed the medical reports and determined the claimant was medically stationary at the time of claim closure, before deciding whether the insurer's notice was sufficient, the court remanded. Id. On remand, we concluded that in order to be entitled to claim closure based on a presumption that the claimant is medically stationary, the notice given by the insurer must be in strict compliance with OAR 436-30-035. Bertha Paniagua, 46 Van Natta 55 (1994). In reaching this conclusion,

we reasoned that the purpose of this rule is not to penalize the worker for failing to see his or her doctor. Rather, we explained, the rule appropriately allows the claim to be closed based on a presumption that, if the worker needed medical treatment, she would have sought medical treatment. However, "the notice given must clearly and plainly state that the claim will be closed if claimant fails to return to her doctor for treatment." Id.

The notice in Paniagua stated only that the claim would be closed if the claimant or her doctor did not contact the insurer within two weeks. Therefore, we found that the notice did not comply with the rule and was, therefore, inadequate to allow claim closure based on a presumption that claimant was medically stationary. Id. The notice in the instant case is similarly flawed. It advised claimant "[i]f we have not heard from your doctor within two weeks from the date of this letter, we will assume you have completely recovered from your injury without disability and proceed to have your claim closed." Thus, we find the employer's notice likewise inadequate to trigger application of the presumption.

In any event, we find the administrative closure procedure outlined in OAR 436-30-035(7) not applicable to this claimant. The rule states that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, unless so instructed by the attending physician. Former OAR 436-30-035(7)(a). Here, when Dr. Epley last examined claimant on April 20, 1992, he advised her to return in three months. Although the rule allows claim closure based on a presumption that, if the worker needed medical treatment she would have sought medical treatment, it clearly does not contemplate claim closure where, as here, an attending physician schedules medical treatment at intervals greater than 28 days.

Consequently, because we find that the employer sought and obtained closure under former OAR 436-30-035 based upon a presumption to which it was not entitled, we conclude that the claim was prematurely closed. Accordingly, we set aside the Determination Order.[1]

Extent of Permanent Disability

As we have found that claimant's claim was prematurely closed, we do not reach the issue of extent of permanent disability.

ORDER

The Referee's order dated June 10, 1993 is reversed. The Order on Reconsideration is vacated and the Determination Order is set aside as premature. The claim is remanded to the self-insured employer for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

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[1] ORS 656.331(1)(b) provides that, where claimant is represented by counsel, the employer shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the termination of the worker's benefits. ORS 656.268(2)(b) provides that, when the employer seeks closure from the Department, copies of all medical reports shall be furnished to the Department. Finally, former OAR 436-30-030(4) (WCD Admin. Order 5-1992) provides that the employer shall notify the worker's representative when a request for determination is made to the Department. Compliance with these statutes and the rule may well have negated the need for further litigation on this matter.

In the Matter of the Compensation of
MICHAEL W. FEREBEE, Claimant
WCB Case No. 92-11679
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of that portion of Referee Myzak's order that directed it to pay an approved attorney fee, even though claimant's entire permanent disability award had already been paid to claimant. On review, the issues are entitlement to and payment of an approved attorney fee. We affirm in part and modify in part.

FINDINGS OF FACT

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

SAIF paid claimant's entire 14 percent scheduled permanent disability award directly to claimant.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning concerning claimant's counsel's entitlement to an approved attorney fee. See Jane A. Volk, 46 Van Natta 681 (1994).[1] However, we modify the order regarding the process for recovering that fee, as follows.

Since the compensation has already been paid to claimant, her attorney must first seek recovery of the fee directly from claimant. Jane A. Volk, supra. In the event that the attorney's efforts to recover the fee directly from claimant are unsuccessful, claimant's attorney may choose to recover the fee in the following manner.

Claimant's attorney may present written documentation of the attorney's collection efforts to the employer. This documentation, which shall be accompanied by claimant's attorney's affidavit certifying to the truth and accuracy of the representations contained therein, shall establish: (1) the amount of the unpaid attorney fee; and (2) that claimant has failed to fully satisfy the remaining balance due on the unpaid fee within 14 days from claimant's attorney's written demand to claimant for payment.

In addition to this documentation, claimant's attorney should request that the employer reimburse the attorney for any unpaid balance owing from claimant concerning the fee. This reimbursement shall be paid by the employer directly to claimant's attorney from any future permanent disability awards granted on the claim.

If claimant's attorney satisfies the aforementioned procedural requirements, the employer shall be required to first pay any of claimant's future permanent disability awards on the claim to the attorney in an amount sufficient to satisfy the remaining balance due on the unpaid attorney fee. If claimant's initial future award is insufficient to fully satisfy the unpaid attorney fee, this Board authorization of the lien shall continue until claimant's attorney's fee is fully paid. Once the unpaid attorney fee is fully satisfied, the employer shall pay the remaining future permanent disability awards to claimant in the usual fashion.

In summary, claimant's attorney is entitled to a fee payable from claimant's "increased" compensation. In accordance with statutory and administrative requirements (as well as claimant's retainer agreement), claimant's attorney shall seek recovery of that fee from claimant. Should those recovery efforts prove unsuccessful, claimant's attorney may elect to seek to recover any unpaid portion of the fee from claimant's future permanent disability awards in the manner detailed above.

ORDER

The Referee's order dated August 10, 1993, is modified in part and affirmed in part. That portion of the order that directed the SAIF Corporation to pay an approved attorney fee is modified. This fee shall be recovered either: (1) directly by claimant's attorney from claimant; or (2) indirectly from claimant's future permanent disability awards on this claim, provided that claimant's attorney

[1] Although signatory to this order, Member Gunn would direct the parties to his dissent in Volk supra.

submits the required documentation to SAIF in accordance with the procedures set forth in this order. The remainder of the order is affirmed.

In the Matter of the Compensation of
RUSSELL H. FOWLER, Claimant
WCB Case No. 91-13314
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
John T. Bagg (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Fowler v. Eastern Oregon Custom Coaters, 123 Or App 633 (1993). The court has reversed our prior order, Russell H. Fowler, 44 Van Natta 349 (1992), which affirmed that portion of a Referee's order that 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. Citing Pacheco-Gonzales v. SAIF, 123 Or App 312 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

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

As a result of the compensable injury, claimant has no left thumb extension or abduction. His left thumb metacarpal phalangeal range of motion is -30 degrees to 60 degree flexion and his left thumb interphalangeal range of motion is -20 degrees extension to 80 degrees flexion. His left index finger has normal range of motion. His left middle finger has 0 to 90 degrees range of motion of the MP joint, -10 to 90 degrees of the PIP joint, and 0 degrees of the DIP joint. His left ring finger has 0 to 90 degrees range of motion of the MP joint, 0 to 90 degrees of the PIP joint, and 0 degrees of the DIP joint. His left little finger has -20 to 75 degrees range of motion of the MP joint, -20 to 40 degrees of the PIP joint, and 0 degrees of the DIP joint. He retains 20 percent of left grip strength and his left elbow range of motion, flexion and extension, is 0 to 140 degrees.

Dr. Nelson, orthopedist, made the above-described findings and Dr. Gill, treating physician, concurred with them. (Exs. 13, 14).

CONCLUSIONS OF LAW AND OPINION

An October 15, 1990 Notice of Closure awarded 61 percent scheduled permanent disability for loss of use or function of claimant's left arm. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The August 30, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Notice of Closure in all respects.

A medical arbiter examined claimant on September 4, 1991. Claimant requested a hearing on September 16, 1991.

At hearing, Exhibits 1-27 were admitted, including the "post-reconsideration" September 4, 1991 medical arbiter's report. Testimony was also taken. Claimant argued entitlement to an unscheduled permanent disability award for his left shoulder; sought payment of his scheduled award at a rate of $305 per degree; requested penalties and attorney fees based on SAIF's failure to pay the scheduled award at that rate; and argued that the Director's October 1990 temporary disability standards are invalid. SAIF contested claimant's scheduled permanent disability award.

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. Claimant requested Board review.

In our prior order, we affirmed the Referee's order. Russell H. Fowler, supra. We relied primarily on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992). Claimant appealed.

The court has reversed our order in Olga I. Soto, supra, citing Pacheco-Gonzalez v. SAIF, supra. In Pacheco-Gonzalez, 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. Pacheco-Gonzalez, supra.

In this case, relying on the reasoning expressed in Pacheco-Gonzalez, the court has similarly remanded for reconsideration. Accordingly, we proceed with our reconsideration.

Preliminary Matters

At the outset, we note claimant's argument that the Hearings Division lacks jurisdiction over SAIF's request for reduction in claimant's scheduled permanent disability award, because SAIF did not raise that issue until the hearing convened.

Since the Referee's order, we have held that parties may raise extent of disability issues at hearing, regardless of whether those issues were specifically raised at the reconsideration proceeding. See Darlene K. Bentley, 45 Van Natta 1719 (1993); see also Stephen L. Haley, 46 Van Natta 525 (1994); Ruth E. Griffin, 46 Van Natta 418 (1994); Hugh D. Brown, 45 Van Natta 2188 (1993). Thus, SAIF's failure to raise the extent of scheduled permanent disability issue on reconsideration did not preclude raising that issue at hearing.

Claimant also argued that he was prejudiced due to lack of notice of the issue prior to hearing. However, the Referee explained that the remedy for such surprise would be a continuance, which claimant declined. (See Tr. 2-3). Moreover, when the Order on Reconsideration was appealed, all issues arising from claim closure were before the Referee. See Kristy R. Schultz, 46 Van Natta 294, 295 (1994) (When a party requests a hearing from an Order on Reconsideration, the other party is entitled to raise any issues pertaining to the extent of claimant's permanent disability). Under these circumstances, we conclude that SAIF's request for reduction in claimant's scheduled permanent disability award was properly before the Referee.

As an additional preliminary matter, we note claimant's argument that the temporary rules contained in WCD Admin. Order 15-1990 are invalid. However, subsequent to the Referee's order, we examined our authority to determine the validity of the temporary standards and found it lacking. See Eileen N. Ferguson, 44 Van Natta 1811 (1992). (Board lacks authority to declare temporary rules invalid). In accordance with Ferguson, we are statutorily required to apply the standards adopted by the Director at the relevant time. ORS 656.295(5); See Robert W. Banks, 45 Van Natta 1161 (1993).

In this case, 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 October 15, 1990 Notice of Closure. OAR 438-10-010, 436-35-003(2). Thus, the applicable "standards" are provided in WCD Admin. Orders 7-1988 and 15-1990. See WCD Admin. Order 1-1989.

Unscheduled Permanent Disability

Claimant seeks an unscheduled permanent disability award for a chronic left shoulder condition which limits repetitive use of that body part. In this regard, claimant testified that his left shoulder problems began after his 1988 work injury. Now, every time he lifts his left arm above shoulder height, he experiences severe pain in his shoulder and upper back. (Tr. 36-39; see Ex. 13-2).

Claimant's testimony alone is not sufficient to establish a ratable condition under the standards. Medical evidence is required. See William K. Nesvold, 43 Van Natta 2767 (1991).

The medical evidence regarding the claimed left shoulder impairment is provided by Drs. Corrigan and Brenneke. (Exs. 18, 26). However, because Dr. Brenneke is neither claimant's treating physician nor the medical arbiter (and the treating physician has not concurred with Dr. Brenneke's findings)[1], we are not free to rely on Dr. Brenneke's findings in evaluating claimant's permanent disability. See ORS 656.245(3)((b)(B); Koitzsch v. Liberty Northwest Insurance Corporation, 124 Or App 666 (1994).

Dr. Corrigan, medical arbiter, opined that claimant has no left shoulder impairment and his finding in this regard is essentially uncontroverted. (Ex. 26-5). Under these circumstances, we conclude

[1] Dr. Gill, treating physician, concurred with Dr. Nelson's August 31, 1990 report which expresses no opinion concerning claimant's left shoulder, except that claimant "denies any shoulder discomfort. . . ." (Exs. 13, 14).

that claimant has not established entitlement to an unscheduled permanent disability award for his left shoulder problems.

Scheduled Permanent Disability

At the outset, we note SAIF's request that the case be remanded to the Appellate Unit for consideration of the medical arbiter's examination results. However, because the medical arbiter's report was admitted at hearing and there is no need for the Appellate Unit to review it in the first instance, SAIF's request is denied. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993); Cynthia L. Luciani, 45 Van Natta 1734 (1993).

In evaluating claimant's permanent disability, we consider the impairment findings of Dr. Nelson (with which Dr. Gill, treating surgeon, concurred) and the findings of Dr. Corrigan, medical arbiter. See Alex J. Como, 44 Van Natta 221 (1992). Considering Dr. Gill's advantage as claimant's treating surgeon and his concurrence with Dr. Nelson's findings, we conclude that Dr. Nelson's closing examination provides the most persuasive basis for rating claimant's permanent disability. (See Exs. 13, 14). Because the Order on Reconsideration utilized Dr. Nelson's findings and there is no contention that claimant's disability was improperly calculated, we further conclude that the Order on Reconsideration's award of 61 percent scheduled permanent disability should be reinstated and affirmed.

Rate of Scheduled Permanent Disability

Claimant argues that his scheduled permanent disability award should be paid at a rate of $305 per degree under amended ORS 656.214(2).

However, because claimant was injured before May 7, 1990, amended ORS 656.214(2) does not apply. SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992). Rather, claimant is entitled to be paid permanent disability compensation at the rate in effect at the time of his August 1988 compensable injury. ORS 656.202(2); former ORS 656.214(2). Under these circumstances, claimant is not entitled to a penalty or attorney fee based on SAIF's failure to pay the award at a rate of $305 per degree.

Accordingly, on reconsideration, the Referee's order dated February 14, 1992 is reversed. The August 30, 1991 Order on Reconsideration is reinstated and affirmed.

Finally, claimant is entitled to a reasonable attorney fee award before every prior forum for finally prevailing on the extent of scheduled permanent disability issue. ORS 656.388(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing, on Board review and before the court concerning the extent of scheduled permanent disability issue is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value to claimant of the interest involved. We further note that much of claimant's attorney's efforts have been devoted to claimant's unsuccessful request for an unscheduled permanent disability award and the "rate of scheduled permanent disability" issue.

IT IS SO ORDERED.

April 15, 1994 Cite as 46 Van Natta 748 (1994)

In the Matter of the Compensation of
DUNG D. HO, Claimant
WCB Case No. 90-15088
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Ho v. Wacker-Siltronic, Inc., 124 Or App 207 (1993). The court has reversed our prior order, Dung D. Ho, 44 Van Natta 396 (1992), which: (1) vacated the portion of a Referee's order that set aside the insurer's "de facto" denial of claimant's claim for proposed medical services; (2) vacated the portion of a Referee's order that assessed a $300 attorney fee based on the insurer's unreasonable failure to process that claim; and (3) reversed the portion of the Referee's order that assessed a penalty based on the insurer's allegedly

unreasonable termination of claimant's temporary disability benefits. Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

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

The insurer first received notice of Dr. Flemming's request for authorization to perform facet injection therapy on or about April 6, 1990. (Ex. 6; see Exs. 6A, 6B). Thereafter, Dr. Flemming renewed the same request on May 18, 1990, September 1, 1990, November 5, 1990, and November 7, 1990. (See Exs. 8A, 12A, 19, 20).

Claimant requested a hearing on July 25, 1990. On November 27, 1990, claimant amended his request to include the issue of penalties based on the insurer's failure to process the medical services claim.

The insurer neither accepted nor denied the claim for proposed medical services prior to the December 6, 1990 hearing. At hearing, the insurer asserted that the medical services issue was not ripe, because it had not yet decided whether to accept the claim.

CONCLUSIONS OF LAW AND OPINION

Following a hearing, the Referee issued an order that: (1) set aside the insurer's "de facto" denial of claimant's claim for proposed medical services (facet injection therapy); (2) assessed a $2,300 attorney fee for claimant's counsel's services at hearing; (3) set aside a Determination Order closing claimant's back injury claim; (4) awarded claimant additional temporary disability benefits; (5) assessed a penalty based on the insurer's allegedly unreasonable termination of temporary disability benefits prior to claim closure; and (6) assessed a $300 penalty-related attorney fee based on the insurer's failure to accept or deny the claim for facet injections.

In finding the insurer responsible for the proposed facet injection therapy, the Referee reasoned that the therapy was reasonable and necessary treatment for claimant's compensable back condition. The Referee relied on the opinion and recommendation of Dr. Flemming, treating physician.

The insurer requested Board review regarding claimant's entitlement to temporary disability compensation, the related penalty, and the assessed and "penalty-related" attorney fees based on the "de facto" denial of the claim for facet injections.

We affirmed the Referee's holdings regarding the Determination Order and claimant's entitlement to temporary disability benefits, but reversed his assessment of an associated penalty. Dung D. Ho, supra. We vacated the portions of the Referee's order that: (1) set aside the insurer's "de facto" denial of the claim for proposed facet injection therapy; (2) assessed an attorney fee for prevailing on the medical services claim; and (3) assessed an attorney fee based on the insurer's allegedly unreasonable failure to process that claim. The latter decisions were based on a finding that we lacked jurisdiction over matters concerning proposed medical services.

Claimant requested judicial review of our decision. While that appeal was pending, the court held that jurisdiction over medical services disputes involving proposed medical treatment does reside in the Hearings Division. Jefferson v. Sam's Cafe, supra. Relying on Jefferson, the court has reversed and remanded this case for reconsideration. Accordingly, we proceed with our reconsideration.

Reasonableness and Necessity of Proposed Facet Injection Therapy

We find, as did the Referee, that there is no persuasive reason to discount the opinion of Dr. Flemming, treating physician, regarding the reasonableness and necessity of the proposed facet injection therapy treatments. 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). Accordingly, we adopt the Referee's opinion on this issue, which is found on pages 7 and 8 of the Opinion and Order.

Attorney Fee Based on the Insurer's Failure to Accept or Deny Claimant's Claim for Proposed Medical Services

At hearing, the insurer argued that its failure to process claimant's claim for proposed facet injection therapy was reasonable because claimant's request for hearing on the claim was premature. We disagree with the insurer's argument.

The insurer contended that Dr. Flemming, treating physician, filed a claim for proposed medical services on claimant's behalf sometime before May 28, 1990, withdrew the claim in September 1990, then changed his mind and recommended the same services again in November 1990. Specifically, the insurer asserted that Dr. Flemming's September 7, 1990 letter "concurring" with the Western Medical Consultants' August 1990 report (which did not recommend such a course of treatment) constituted a withdrawal of the prior claim for proposed facet injection therapy. Thus, according to the insurer, when Dr. Flemming later proposed the same treatment, in November 1990, it was a "new" claim (not a continuing claim), and the 60-day period allowed for investigating the new claim (allowed under former ORS 656.262(6)) had not run when claimant requested a hearing. Under these circumstances, the insurer asserted that its failure to accept or deny the claim prior to hearing was not unreasonable. We disagree for the following reasons.

Dr. Flemming initially requested authorization for facet injection therapy for claimant in April 1990. He renewed this request on May 18, 1990, September 1, 1990, November 5, 1990, and November 7, 1990. (See Exs. 8A, 12A, 19, 20).

In August 1990, Western Medical Consultants opined that "no further active medical or diagnostic treatments are indicated." (Ex. 15-4). By letter dated September 7, 1990, Dr. Flemming responded, "I agree with the doctors' report from Western Medical Consultants, although feel that [claimant] would have benefitted and returned to work more quickly had he had the facet injections to settle down his facet discomfort." (Ex. 17).

In our view, the September 1990 letter was not a complete concurrence with Western Medical Consultants' report. Dr. Flemming expressly opined that facet injections would have been beneficial for claimant. Moreover, considering this opinion, in light of Dr. Flemming's later statement that he "certainly continu[ed] to feel that [claimant] would benefit from a trial of facet injections[,]" (Ex. 20, emphasis added), we conclude that Dr. Flemming did not withdraw his recommendation for facet injection therapy. (See Exs. 19, 20). On this record, we further conclude that Dr. Flemming's September 1990 letter is not reasonably interpreted as a withdrawal of the claim for proposed medical services.

Under these circumstances, Dr. Flemming's request for authorization to perform facet injection therapy amounted to a continuing claim, which was first filed in April 1990. Because the insurer did not accept or deny that claim within 60 (or 90) days, the claim was in "de facto" denied status when claimant amended his July 25, 1990 hearing request on November 27, 1990 to include the issue of penalties based on the insurer's failure to process the medical services claim. See ORS 656.262(6); former ORS 656.262(6); Barr v. EBI Companies, 88 Or App 132 (1987). In addition, because claimant amended his request for hearing to include the medical services issue after the statutory period for investigating the claim had expired, we further conclude that the request for hearing was not premature and the medical services issue was properly before the Referee. Compare Syphers v. K-W Logging, Inc., 51 or App 769, rev den 291 Or 151 (1981); Barr v. EBI Companies, supra.

We would reach the same conclusion even if the 60-day period for investigation of the claim was "tolled" during the 6 weeks claimant was out of the country. Assuming without deciding that such a theory was valid, we would nonetheless conclude that the April 1990 claim was effectively denied by the time claimant amended his hearing request on November 27, 1990.

Finally, because the requested services are compensable and we find that the failure to process the claim was unreasonable, we agree with the Referee that the insurer's conduct amounted to an unreasonable resistance to the payment of compensation. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984). Because the requested medical services were not provided and the record reveals no amounts owing under the compensable claim, there are no "amounts then due" which would otherwise support a penalty under ORS 656.262(10). See Richard J. Stevenson, 43 Van Natta 1883 (1991). In light of such circumstances, and after considering the factors set forth in OAR 438-15-010(4), we conclude that the Referee's $300 attorney fee assessment on this basis was reasonable. See ORS 656.382(1); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992); Deborah K. Jennings, 46 Van Natta 25 (1994).

Penalty Based on Unilateral Termination of Temporary Disability Benefits

We republish our opinion on this issue, which is found on page 2 of our Order on Review.

Claimant has finally prevailed after remand with respect to his medical services claim for proposed medical treatment. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314,

1315 (1991). Inasmuch as we have affirmed the Referee's order finding the medical services to be compensable and awarding an assessed attorney fee of $1,400, it is unnecessary to address claimant's entitlement to an attorney fee for services at the hearing level. Thus, we proceed to address claimant's entitlement to an attorney fee at the Board and court levels.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at both appellate levels regarding the medical services issue is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration of our March 5, 1992 order, the Referee's order dated December 21, 1990, as reconsidered January 29, 1991, is reversed in part and affirmed in part. That portion of the order that assessed a penalty based on the insurer's unilateral termination of claimant's temporary disability compensation is reversed. The remainder of the order is affirmed. Claimant's attorney shall receive a $2,000 attorney fee, payable by the insurer, for services rendered on review at the Board and court.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID B. KOEPPING, Claimant
WCB Case No. 92-08475
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Hazelett's order which upheld the self-insured employer's denial of his claim for a psychiatric condition. In his brief, claimant requests reopening of the record for submission of further evidence. We treat claimant's submission of additional evidence as a request for remand to the Referee for further evidence taking. ORS 656.295(5). On review, the issues are remand and compensability. We deny the motion to remand and reverse the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact, except the first and last paragraphs of the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant requests remand for further evidence taking on the issue of whether he was an employee at will. Claimant has also submitted a memo from the employer for the purpose of rebutting certain witness testimony offered by the employer at hearing.

We conclude that a remand would not be appropriate, because claimant has not shown that the additional evidence could not have been obtained with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In any event, the request for remand is moot, as we conclude that claimant is entitled to benefits for work-related stress even without consideration of the proffered evidence.

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. ORS 656.802(2). In addition, the employment conditions producing the mental disorder must exist in a real and objective sense. ORS 656.802(3). 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). The claimant has the burden to prove by clear and convincing evidence that work-related stressors, not otherwise excluded by ORS 656.802(3), are the major contributing cause of his mental disorder. See Thrash v. City of Sweet Home, 111 Or App 27 (1992).

In its respondent's brief, the employer accepts the Referee's findings of fact, and we have adopted those findings (with certain exceptions noted above). In summary, claimant has a mental disorder (anxiety and depression) that is recognized as such in the medical community. Claimant

became depressed as a result of being removed by the employer from the supervisory position he had held for 10 years.

Claimant was removed from his job and demoted to a line mechanic because various company managers had complained about his failure to attend certain weekly management meetings. Although they had been complaining for many years, these managers never related their concerns to claimant, but, instead, made them to Mr. Williams, claimant's immediate supervisor, and to Mr. Brentano, the Department Director. Despite these complaints, claimant was allowed by his superiors to work independently. Furthermore, in the March 1991 written performance evaluation, Mr. Williams commended claimant for the quality of his managerial communication, his participation in group discussions, and his supervision of employees. Mr. Brentano approved and signed the evaluation as the Department head. Nonetheless, Messrs. Brentano and Williams remained dissatisfied with claimant's record of attendance at the meetings. Without informing claimant, Mr. Williams asked a Mr. Scott to closely supervise claimant's work performance, his primary charge being to get him to attend more meetings. However, as far as claimant knew, Mr. Scott was simply a colleague. Mr. Scott encouraged claimant to attend more meetings, but to no avail. Ultimately, Messrs. Scott and Williams met privately with Mr. Brentano, who decided to remove claimant from the supervisory position. On March 31, 1992, Mr. Williams told claimant that he was demoted to maintenance mechanic. This was the first notice claimant received that his failure to regularly attend the meetings was considered by higher management to be such an egregious work performance deficiency that he could lose his supervisory job for that reason. As a result of the summary demotion, claimant became depressed and sought medical treatment.

As a supervisor, claimant was a member of management, and outside the bargaining unit. Consequently, he could not file a contractual grievance about the demotion. Furthermore, the employer did not have any written personnel policies which gave supervisory employees like claimant the right to grieve a disciplinary action for lacking "just cause" or reasonable foundation. Accordingly, the Referee found that claimant was an "at will" employee, for whom even employment termination without notice and without just cause was a condition generally inherent in every working situation. Alternatively, the Referee found that given claimant's "at will" status, his demotion constituted reasonable discipline, since again, an "at will" employee is subject to being disciplined summarily, without prior notice of the seriousness of any perceived work performance deficiencies. We disagree with the Referee's reasoning and conclusions, and reverse.

It is true that an "at will" employee may not have any valid legal recourse against an employer for disciplinary action that would be considered unreasonable if judged according to basic tenets of personnel administration. However, whether or not claimant may challenge the discipline in a court action for wrongful discharge or on some other legal basis is not the issue before us. The question before this Board under ORS 656.802(3)(b), is whether claimant's summary demotion was reasonable discipline, or if the actions taken were conditions generally inherent in every working situation. Whether the employee has a right under contract or law to seek monetary relief or other remedies for the action is a factor to be considered with the entire circumstances, but alone, it is not controlling. Considering the entire circumstances in this case, and despite claimant's apparent "at will" status, we conclude that his summary demotion was not reasonable discipline, and the actions taken are not conditions generally inherent in every working situation.

Whether or not discipline is reasonable must be decided on a case-by-case basis, taking into account the particular facts of the case. However, we are satisfied that even when not required by contract or law to do so, employers disciplining reasonably endeavor to follow certain fundamental principles of personnel administration, particularly when dealing with first line supervisors and their subordinates, because the principles lead to good decision making.

Any employer has the right to expect its managers to conform their conduct to even very strict standards of behavior. Such standards may be enforced by the company through the imposition of discipline up to and including discharge.

The primary distinction between a manager and his or her subordinates, generally, is the higher level of accountability that a manager must accept with the authority and responsibility that his position carries. For example, a Department head, having ultimate responsibility for the proper functioning of a department, expects to and is usually judged primarily according to "intangibles," such as "leadership." One takes such a job, understanding that he or she may be summarily removed for no reason other than the company's desire for a different policy emphasis or approach. On the other hand, first line supervisors share much in common with the employees they supervise. As to them, an employer

disciplining reasonably will attempt to salvage the investment the employee represents, and, to that end, will consider the employee's length of service and prior service record in determining what level of discipline would be appropriate and if alternatives to serious discipline should be first tried. Furthermore, because the primary purpose of discipline is to correct a performance deficiency rather than to punish, an employer disciplining reasonably will, before imposing severe discipline (such as discharge or demotion), try to ensure that the first line supervisor or subordinate involved is given adequate notice that the deficiency is considered a "capital" offense. With the benefit of such notice, the employee is made to understand that his job is in jeopardy, and, thus, he must redouble his efforts to improve his work performance in order to save his job.

Here, the employer did not follow certain of these basic principles in dealing with the claimant. The primary problem was lack of notice and precipitous action.

Claimant had worked 18 years for the employer, the last 10 years as a supervisor. He had been promoted as a supervisor from a maintenance mechanic position. Throughout his years as a supervisor, claimant did not attend the weekly manager meetings. Although complaints were made, they were not made to claimant. Rather, claimant was commended by his superiors for the quality of his work. Particularly given this history, claimant had no reason to suspect that suddenly in 1992 his failure to attend the meetings would be treated as a "capital" offense. In view of this long history of employer acquiescence, it was incumbent on the employer, if disciplining reasonably, to notify claimant in no uncertain terms that his attendance at the weekly meetings was required and that he would be subject to serious discipline for failing to attend. Rather than giving claimant such notice and a reasonable opportunity to improve, claimant was supervised secretly by someone the company deliberately did not identify as claimant's supervisor, and then he was summarily removed from his position. We conclude that the action taken by the employer did not constitute reasonable discipline.

We also conclude that the actions taken were not conditions generally inherent in every working situation. On the contrary, much of what happened here was very unusual. Employees ordinarily are purposefully made to know who their supervisors are, and, ordinarily, a mid-level manager like claimant would be confronted directly and promptly by his superiors for failing to attend management staff meetings. In other words, we conclude that being subject to severe discipline that does not comport with the most fundamental tenets of personnel administration is not a condition that is generally inherent in every working situation.

In summary, we conclude that claimant has established, by clear and convincing evidence, that work-related stressors, not otherwise excluded by statute, were the major contributing cause of the mental disorder. Therefore, we reverse the Referee's order and set aside the employer's denial.

Claimant was not represented by an attorney on Board review of the case, and therefore he is not entitled to an attorney fee award for prevailing before the Board. However, claimant was represented by an attorney at hearing, and claimant's attorney is entitled to an assessed fee for such services. After considering the factors set forth in OAR 438-15-010(4), we find that $3,500 is a reasonable attorney fee. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by the record), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney might go uncompensated for his services.

ORDER

The Referee's order dated November 24, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing, claimant's attorney is awarded an attorney fee of $3,500, payable by the employer.

Board Member Haynes dissenting.

The majority concludes that claimant's demotion was not reasonable, because the employer did not act reasonably in doing so, and also concludes that the actions taken by the employer in demoting claimant were not conditions generally inherent in every working situation. Because the majority has imposed an improper standard of conduct upon the employer in the workers' compensation system, I disagree that the employer's disciplinary process was unreasonable. I further disagree that the manner and circumstances of the demotion were not conditions generally inherent in every working situation. Because I disagree with both conclusions reached by the majority, I dissent.

Claimant's former position was as the facilities maintenance supervisor. Although both the Referee and the majority discuss claimant's status as an "employee at will," such a finding is

unnecessary to determining whether the disciplinary, corrective or job performance evaluation actions by the employer were reasonable. As the majority correctly points out, our job is not to determine whether claimant has a right under contract or law to seek remedies for the employer's actions. Our function is to determine the compensability of claimant's workers' compensation claim for mental stress.

The majority enunciates certain standards that a reasonable employer should consider when invoking discipline. After considering this standard, the majority concludes that the employer did not act reasonably, by finding that the employer did not give claimant adequate notice of and opportunity to respond to his job deficiencies.

I, however, do not read ORS 656.802(3) as a reasonable employer standard. We have previously determined the reasonableness of an employer's actions on a case-by-case basis. See Daniel A. Jackson, 43 Van Natta 2361, 2366 (1991) (Member Gunn, specially concurring). Thus, adequate notice is merely one of several factors considered in determining whether the employer's disciplinary actions were reasonable.

Moreover, the majority's analysis instills a "reasonable/prudent" tort standard into a no-fault workers' compensation system. This Board, however, can and should determine whether the circumstances and manner of discipline by the employer were reasonable without introducing fault concepts in the workers' compensation law. See Elwood v. SAIF, 298 Or 429, 433 (1985).

The record in this case establishes that it was reasonable for the employer to correct claimant's job deficiencies. Testimony from employer witnesses Miller and Bryant, bus maintenance facility managers; Brentano, director of bus maintenance and facilities; and Williams, facilities manager, indicate that claimant's supervisory performance was deficient in a number of areas, including daily contact with the bus maintenance facility managers, regular visitation to the bus garages, attending monthly meetings, and lack of supervision of his employees.

The record also establishes that adequate notice was given to claimant. Given the employer's size and the multiple locations of its facilities, proper channels of communication were necessary for efficient operation. It was not the role of the other managers with which claimant dealt to directly voice their complaints and concerns to claimant. Rather, they reported their complaints to Mr. Williams, claimant's immediate supervisor, or to Mr. Brentano, who was Mr. Williams' supervisor. Mr. Williams had verbally advised claimant of his deficiencies. These discussions were held in private.

In August 1991, Mr. Scott began supervising claimant's day-to-day activities. At that time, he advised claimant that upper management had problems with his performance as a supervisor. He also advised claimant of the need to attend meetings, to visit garages, etc. In December 1991, Mr. Scott reported to Mr. Williams that he was unable to make progress with claimant and asked him to intervene.

In January 1992, Mr. Williams requested claimant to draft job performance standards and goals. This document was another means by which Mr. Williams communicated with claimant regarding his job performance. However, claimant did not produce his goals and objectives until mid-March 1992. Based, in part, on claimant's failure to show improvement, Messrs. Williams and Brentano made the ultimate determination that claimant was unable to carry out his supervisory duties and that claimant should be demoted. On March 31, 1992, Mr. Williams informed claimant that he was demoted.

Based on the facts of this case, I would find that claimant had adequate notice of his job deficiencies and that the employer's actions in demoting claimant were reasonable.

The majority also concludes that the employer's actions were "very unusual" and therefore were not conditions generally inherent in every working situation. We have interpreted the phrase "generally inherent in every working situation" to mean conditions that are usually present in all jobs or occupations and not merely the specific occupation involved. See Kathleen M. Payne, 42 Van Natta 1900, 1906 on recon 42 Van Natta 2059 (1990), rev'd on other grounds, City of Portland v. Payne, 108 Or App 771 (1991).

Because I would find that the manner and circumstances of claimant's demotion were reasonable, I would find that the work-related stressor, claimant's demotion, was a condition generally inherent in every working situation.

Based on the foregoing reasoning, I would conclude that claimant failed to establish a compensable mental stress claim under ORS 656.802(3). Therefore, I respectfully dissent.

In the Matter of the Compensation of
LLOYD S. ABRAHAM, Claimant
WCB Case No. 92-14829
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
James W. Moller (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our March 24, 1994 Order on Review that: (1) found that the Referee had jurisdiction over claimant's timely request for hearing from SAIF's aggravation denial; and (2) affirmed the Referee's order setting aside SAIF's denial of claimant's aggravation claim for a low back condition. Specifically, SAIF requests reconsideration for three reasons: (1) to clarify the nature of its argument concerning claimant's failure to perfect a claim for aggravation; (2) to point out factual errors in our prior order; and (3) to challenge the "waxing and waning" (aggravation) issue on the merits.

In order to further consider SAIF's contentions, we withdraw our March 24, 1994 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNI J. MEAD, Claimant
WCB Case Nos. 93-03486 & 93-02288
ORDER OF ABATEMENT
Robert G. Dolton, Claimant Attorney
Roberts, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

American International Adjustment Company, Inc. (AIAC), requests reconsideration of our March 17, 1994 Order on Review which held that responsibility for claimant's low back condition remained with AIAC.

In order to allow sufficient time to consider the motion, we withdraw our March 17, 1994 order. Liberty Northwest Insurance Corporation and claimant are granted an opportunity to respond to AIAC's motion. To be considered, those responses 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
RICHARD N. WIGERT, Claimant
WCB Case Nos. 91-02200
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

The insurer requests abatement and reconsideration of our March 23, 1994 Order on Review that: (1) denied its motion for remand of the case to the Referee for the taking of additional evidence; and (2) affirmed the Referee's order that set aside its partial denial of claimant's right ankle osteophyte condition and associated need for excision surgery. The insurer argues that the Board erred in declining to remand the case to the Referee for the taking of additional evidence from Dr. Dickerman, examining physician. On reconsideration, the insurer requests that this matter be reviewed by the Board en banc.

As a preliminary matter, we deny the insurer's request for en banc review of this case. Although the Board may sit en banc in rendering a decision, it may also sit in panels. See Or Laws 1991, ch 954 Sec. 3. When sitting in panels, a majority of the particular panel may issue the Board's decision. See id. Whether a case is reviewed en banc is a matter that the Board decides on its own motion. Such review may not be initiated by a party. After reviewing this case, the insurer's request for en banc review is denied. See Ralph L. Witt, 45 Van Natta 449 (1993) (on recon); Kurt D. Cutlip, 45 Van Natta 79 (1993) (on recon); Brenda K. Allen; 45 Van Natta 2476 (1992) (on recon).

We note that, in requesting en banc review of this case, the insurer characterized the Board's order denying remand as a broad policy decision which, if allowed to stand, "will be a landmark for any party who wishes to use a limited remand as an opportunity to revise testimony, in a surprise fashion, without opportunity for rebuttal." We disagree with the insurer's characterization of our order. We made no broad policy decision. Instead, we applied longstanding legal principles regarding remand and the discretion of referees to reopen the record for consideration of new material evidence.

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).

On April 30, 1992, the Board issued an order remanding the case to the Referee to reopen the record for additional evidence regarding claimant's right ankle condition. The Board directed that, "[i]n addition to the evidence submitted by claimant, the Referee shall allow the insurer an opportunity to cross-examine or rebut claimant's evidence." In addition, the Referee was instructed to proceed in any manner which would achieve substantial justice.

Following the Board's remand of this case to the Referee, a hearing was convened on March 24, 1993, and Exhibits 1 through 41 were admitted into evidence. These exhibits included additional evidence submitted by claimant, as referenced in the Board's April 30, 1992 order, as well as several rebuttal exhibits submitted by the insurer. Claimant had received all but one of the insurer's rebuttal exhibits on the day of hearing. Therefore, the Referee continued the hearing to allow claimant an opportunity to rebut the insurer's evidence.

The hearing reconvened on August 16, 1993 and, over the insurer's objection, the Referee allowed claimant to testify. The insurer was allowed full opportunity to cross-examine claimant. The insurer argues that the Referee erred in allowing claimant to testify at the reconvened August 16, 1993 hearing. We disagree.

As the Referee found, the insurer's rebuttal evidence placed in issue claimant's correct medical history. Under OAR 438-07-023, the "party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on that issue." Here, claimant had the burden of proof regarding the compensability of his current right ankle condition. As the party with the burden of proof, claimant had the right of last presentation of evidence. Here, that evidence was claimant's testimony. In other words, claimant had a right to rebut the insurer's evidence with his testimony. The insurer had the opportunity to cross-examine claimant.

After the record was closed and the Referee issued his order setting aside the insurer's partial denial, the insurer requested reconsideration of that order. The insurer argued that it was surprised by claimant's testimony and requested that the Referee reopen the record for additional evidence. This additional evidence consisted of a recorded statement from Dr. Dickerman, a diagram allegedly completed by claimant, and handwritten notes from Dr. Dickerman. On reconsideration, the Referee denied the insurer's request to reopen the record and republished his original order in its entirety.

We continue to find that the Referee did not abuse his discretion in refusing to reopen the record for the admission of additional evidence from Dr. Dickerman. OAR 438-07-025(1). Furthermore, if a party is surprised by new evidence introduced at hearing, the remedy is for the "surprised" party to request a continuance at the hearing. Kenneth W. Metzker, 45 Van Natta 1631 (1993). Here, at hearing, the insurer did not indicate that it was surprised by claimant's testimony nor did it request a continuance. Instead, it cross-examined claimant and proceeded on the merits.

In addition, if the Referee had reopened the record to admit the additional evidence submitted by the insurer, he would have deprived claimant, the party bearing the burden of proof, of the right to last presentation of evidence on the issue of compensability. OAR 438-07-023; Mike K. Barreras, 43 Van Natta 832, 833 (1991). Such an action would have been an abuse of the Referee's discretion. Id.

Finally, as noted in our March 23, 1994 order, we agree with the Referee that, even if the proffered evidence was admitted, it would not change the result. Therefore, the additional evidence does not merit remand because it is not 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).

Accordingly, we withdraw our March 23, 1994 order. On reconsideration, as supplemented herein, we adhere to our March 23, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 19, 1994 Cite as 46 Van Natta 757 (1994)

In the Matter of the Compensation of
DEBRA C. LAYNG, Claimant
WCB Case No. 90-17162
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Layng v. Edgewood Nursing Home, 123 Or App 628 (1993). The court has reversed our order, Debra C. Layng, 44 Van Natta 815 (1992), which affirmed a Referee's order dismissing claimant's hearing request concerning a medical treatment dispute. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

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

Claimant was obese prior to her compensable 1984 right shoulder injury. Her weight has always fluctuated. (Exs. 44-1, 35-5, Tr. 27).

Claimant's injury was evaluated by Drs. Butters, Wong, Smith, and Rosenbaum prior to claim closure. (Exs. 3, 4, 8, 16, 17, 18, 19 and 20). She continued to treat with Dr. Thomas, chiropractor, for her right shoulder girdle and bicipital tendinitis conditions through June 1987. (Exs. 22 and 24).

On November 12, 1987, Dr. Kincade, claimant's attending physician, recommended pain center therapy for claimant's chronic pain from her cervical and lumbar strains. He also found that claimant was chronically, morbidly obese, weighing over 280 pounds, and suffered from hip, knee, foot and wrist pain related to the obesity. (Ex. 26).

In March 1988, Drs. Rich, McKillop and Thompson recommended against further treatment, including pain clinic treatment. (Ex. 28). In June 1988, Dr. Kincade responded to their opinion. (Ex. 31).

On April 4, 1988, the insurer denied pain center treatment as unrelated to claimant's accepted injury. (Ex. 30). By a July 26, 1988 order, a prior referee found claimant's request for a pain center consultation compensable and the denial premature. (Ex. 33).

On September 14, 1988, Dr. Holmes evaluated claimant's chronic right shoulder, neck, upper extremity and low back pain. He diagnosed cervical and shoulder girdle myofascial syndrome and right bicipital tendinitis, lumbar myofascial syndrome, adult adjustment reaction, and exogenous obesity (5'1", 268 lb.). (Ex. 35-7). As a preliminary to considering claimant for pain center treatment, Dr. Holmes required her to demonstrate her motivation by losing weight to 225 pounds, walking or swimming daily, participating in a women's support group, and defining her vocational goals. (Ex. 35).

In June 1989, Dr. Holmes released claimant to modified light work. On July 26, 1989, Dr. Holmes concluded that claimant had made no progress towards entry into the pain center program. (See Exs. 38, 39, 41, 42 and 43).

By an October 10, 1989 letter, the self-insured employer's claims processing agent agreed to pay for two months of swim exercise and to refer claimant to a vocational counselor, but declined to pay for a weight loss program, as unrelated to the compensable injury. (Ex. 43A).

On December 6, 1989, Dr. Holmes declined to recommend claimant to a managed weight loss program on the basis that it was not related to her injury. (Ex. 45).

At a December 19, 1989 consultation, Dr. Flanagan examined claimant and took a history from her for purposes of determining whether to perform stomach stapling surgery to aid her in weight loss. (Tr. 2). Claimant has decided not to proceed with the surgery.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing for lack of jurisdiction pursuant to ORS 656.327. We affirmed the Referee's order on February 25, 1992, as reconsidered on April 23, 1992. 44 Van Natta 815 (1992). Claimant then requested judicial review.

Citing Meyers v. Darigold, Inc., supra, the court has now reversed our April 23, 1992 order and remanded for reconsideration. Layng v. Edgewood Nursing Home, supra.

Here, the employer did not issue a formal denial of claimant's medical services claim and did not pay the bill. Neither the parties nor the Director requested review pursuant to ORS 656.327(1). Therefore, the Board has jurisdiction to address this medical treatment dispute. Meyers v. Darigold, Inc., supra.

Claimant contends that she has had a pain problem since her 1984 shoulder injury and that weight loss has been recommended as a means to alleviate her pain. She further contends that her consultation with Dr. Flanagan is a diagnostic service to determine the appropriateness of surgery for weight reduction and that the medical bill is therefore compensable.

The insurer argues that Dr. Flanagan's bill is not a bill for a diagnostic procedure, in that neither the nature of claimant's obesity nor its cause was in question. Rather, it argues, claimant's consultation with Dr. Flanagan involved an explanation of the risks and benefits of the stomach stapling surgical procedure to aid claimant in evaluating whether she wanted to go forward with the surgery.

Under ORS 656.245(1)(a), "for every compensable injury," a worker is entitled to "medical services for conditions resulting from the injury[.]" The statute extends to payment of diagnostic services relating to noncompensable conditions if such procedures are performed to determine whether or not a causal relationship exists between the industrial injury and the noncompensable condition. See Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Kenneth M. Simons, 41 Van Natta 378, 380 (1989).

Claimant was obese prior to her injury. Her weight has always fluctuated. Although doctors who treated claimant noted her obesity, none recommended weight loss to treat her shoulder injury.

In November 1987, Dr. Kincade, claimant's attending physician, recommended pain center therapy for chronic pain from her cervical and lumbar strains. In March 1988, Drs. Rich, McKillop and Thompson recommended against further treatment, including pain clinic treatment. (Ex. 28). In June 1988, Dr. Kincade nevertheless recommended evaluation by the pain center, as claimant told him that her pain was the only disabling factor that prevented her from returning to work. (Ex. 31).

This evaluation took place in September 1988. Dr. Holmes recommended physical therapy for a myofascial syndrome and steroid injection for bicipital tendinitis. Noting exogenous obesity, Dr. Holmes opined that claimant's inability to control her weight, which was not related to her injury, not only predisposed her to injury but was significant in perpetuating her chronic pain syndrome. (Ex. 35-8). Preliminary to considering claimant for pain center treatment, Dr. Holmes required her to demonstrate her motivation by losing weight to 225 pounds, walking or swimming daily, participating in a women's support group, and defining her vocational goals.

In July 1989, Dr. Holmes concluded that claimant had made no progress towards entry into the program and, in December 1989, more than a year after his initial pain center evaluation, he declined to recommend claimant for a managed weight loss program, on the basis that her obesity was unrelated to her injury. Dr. Holmes further opined that claimant's industrial injury and its sequelae were minor contributors to her chronic "disabilities," i.e., the factors that prevented her return to work. Dr. Holmes did not recommend weight loss as a means to alleviate claimant's pain.

We conclude that weight loss was not recommended to treat claimant's compensable pain condition. Furthermore, claimant's obesity is not a compensable condition. Thus, diagnostic services are compensable only if they were rendered to determine whether or not the accepted shoulder injury was a factor in causing claimant's obesity. See Charles W. Womack, 44 Van Natta 2407 (1992); Nathan A. Stevens, 44 Van Natta 1742 (1992).

We conclude that the medical service rendered by Dr. Flanagan on December 19, 1989 is not compensable. Claimant testified that she consulted Dr. Flanagan to ascertain whether she would be an appropriate candidate for surgery to treat her obesity and what the risks and benefits of the surgery would be. Therefore, Dr. Flanagan's medical service was not provided to determine the existence of a causal relationship and, consequently, such a medical service is not compensable as diagnostic services. We do not find the insurer responsible for Dr. Flanagan's bill.

Accordingly, on reconsideration of our February 25, 1992 order, as reconsidered on April 23, 1992, we reverse the Referee's February 8, 1991 order. Claimant's hearing request is reinstated. The employer is not responsible for Dr. Flanagan's bill.

IT IS SO ORDERED.

In the Matter of the Compensation of
MILAN F. SHUBERT, Claimant
WCB Case No. 89-22007
ORDER ON REVIEW (REMANDING TO THE DIRECTOR'S APPELLATE UNIT)
Pozzi, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board en banc.[1]

Claimant requests review of Referee Barber's order that: (1) found that "post-closure" medical reports concerning the extent of claimant's permanent disability were not admissible; and (2) affirmed an Order on Reconsideration that did not award any additional permanent disability. On review, the issues are evidence, extent of permanent disability, and, if claimant is entitled to scheduled permanent disability, rate of scheduled permanent disability. We remand.

FINDINGS OF FACT

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

At reconsideration, claimant submitted Exhibit 48A, a medical report from Dr. Brenneke, a consulting physician, and Exhibit 48B, a letter drafted by claimant's attorney signed and dated by claimant's attending physician, Dr. Tesar, indicating that he concurred with Dr. Brenneke's report. (Exs. 48, 48C). However, neither document was considered during reconsideration. (Ex. 50).

At hearing, claimant offered Exhibits 48A and 48B into evidence. The Referee ruled that they were inadmissible.

Based on Dr. Tesar's concurrence with Dr. Brenneke's findings, claimant has suffered permanent impairment as a result of the surgical repair of a compensable subluxing shoulder condition. The surgical procedure and resulting impairment are not addressed by the applicable standards.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant objects to the Referee's ruling that Exhibits 48A and 48B were not admissible pursuant to ORS 656.268(5) because they are based on a "post-closure" examination. Claimant contends that both documents should be considered. We agree.

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 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 48A and 48B. Therefore, pursuant to Smith and Luciani, those exhibits may be considered in evaluating the extent of claimant's permanent disability.

In addition, we note that while the examination that Exhibit 48A is based on was performed by Dr. Brenneke, a consulting physician, Dr. Tesar, the attending physician, concurred with those findings. See (Ex. 48B). Therefore, the findings in Exhibit 48A are not precluded by ORS 656.245(3)(b)(B). See Dennis E. Conner, 43 Van Natta 2799 (1992); Raymond J. Lindley, 44 Van Natta 1217 (1992).

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[1] As a result of his prior representation of claimant, Member Hall has recused himself from participation in this review. OAR 438-11-023.

While the Referee did not admit Exhibits 48A and 48B, the exhibits are otherwise in the record. Therefore, it is not necessary for us to remand this case to the Referee for admission of those exhibits and we have considered them on review.

Extent of Unscheduled Permanent Disability

Claimant contends that he is entitled to an award of unscheduled permanent disability. Relying on Dr. Brenneke's report, claimant contends that he proved 15 percent permanent impairment and a total unscheduled permanent disability award of 31 percent. In support of his contention, claimant asserts that he is entitled to a 10 percent impairment value for a subluxing left shoulder and Malloear screw removal surgical procedure. This surgical procedure is not addressed by the applicable "standards."

Subsequent to the Referee's order, the court issued its decision in Gallino v. Pontiac-Buick-GMC, 124 Or App 538 (1993). Relying on ORS 656.726(3)(f)(C), the court reasoned that the Director was required to stay further proceedings and adopt temporary rules "upon a finding that a disability is not addressed by existing standards." Since the Board is authorized under ORS 656.295(5) to review the correctness of the Director's application of the standards, the court concluded that the Board has the power to review the Director's application of existing standards to address chondromalacia. Furthermore, because only the Director can grant the relief requested by claimant (the promulgation of a temporary rule), the court has held that, by necessary implication, we are empowered to remand the case to the Director and must do so.

Here, claimant requested reconsideration contending that his disability had been improperly rated. Specifically, claimant asked the Director to stay further proceedings on this claim in order to adopt temporary rules addressing the appropriate values for permanent impairment attributable to the surgical repair of claimant's subluxing shoulder condition. (Ex. 48). Claimant's request was supported by Dr. Brenneke's report which indicated that claimant had sustained 10 percent impairment as a result of the surgical procedure. (Ex. 48A). Although Brenneke reported that this surgical procedure caused permanent impairment, the procedure was not addressed in the applicable "standards."

Without expressly finding that the existing standards adequately addressed claimant's disability, the Director issued an Order on Reconsideration affirming a Determination Order which did not award any permanent disability.

We are compelled to remand to the Director upon a finding that, at the time of the issuance of an Order on Reconsideration, a disability was not addressed by the existing standards and the Director neglected to stay further proceedings and adopt a temporary rule. See ORS 656.726(3)(f)(C); Gary D. Gallino, on remand, 46 Van Natta 246 (1994).

Under these circumstances, we conclude that the Director was required to stay the reconsideration proceedings and promulgate a temporary rule regarding claimant's disability. Id. Likewise, since we are not authorized to adopt such a rule, we are required to remand the case to the Director for promulgation of that rule.

Therefore, we vacate the Referee's order dated June 19, 1992. In accordance with the Gallino decision, we remand this case to the Director for further proceedings consistent with this order. Inasmuch as we are remanding this matter to the Director, we do not reach the other issues raised by claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
LANNY D. ANGIER, Claimant
WCB Case No. 93-03300
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

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

Claimant argues that, under Barnett v. SAIF, 122 Or App 279 (1993), on remand Betty Barnett, 46 Van Natta 9 (1994), he was entitled to prove the compensability of his low back condition without resort to expert medical evidence. We disagree.

In Barnett, the Court of Appeals reiterated the test set forth in Uris v. Compensation Department, 247 Or 420 (1987), which allows claimants in certain uncomplicated injury cases to establish causation without the submission of expert medical evidence. The Uris test requires, inter alia, that the claimant's symptoms appear immediately and that the claimant promptly report the occurrence to a superior. Id. at 426; see Barnett v. SAIF, supra, 122 Or App at 283.

Here, the record reveals that claimant first noticed his back pain several hours after his work injury to his right hand. (Ex. 6; Tr. 7). It appears that claimant first reported his back problems to one of his physicians nearly a month after the hand injury incident. (See Ex. 10). However, it is unclear when (or if) claimant reported his back condition to a superior.[1] Because the record is silent regarding when the employer learned about claimant's back condition, we conclude that claimant has failed to meet the prompt reporting element of the Uris test. Therefore, we disagree with claimant's contention that there was no need for medical evidence and we agree with the Referee's conclusion that claimant has failed to meet his burden of proof.

ORDER

The Referee's order dated July 30, 1993 is affirmed.

[1] In his brief, claimant asserts that he reported his low back symptoms the day after his original work injury. Aside from the fact that that assertion does not state to whom the alleged report was made, that assertion is not supported by the record.

In the Matter of the Compensation of
DOUGLAS R. BAAR, Claimant
WCB Case No. 92-13378
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Holtan's order that set aside its partial denial of claimant's claim for a hypertension condition. Claimant requests review of that portion of the order that affirmed a Director's order finding that housekeeping services are not reimbursable medical services. Alternatively, claimant argues that the Director's order is not supported by substantial evidence. In addition, claimant contends that the Referee erred in excluding Ex. 30, a letter from claimant's treating physician. On review, the issues are compensability, medical services, sufficiency of the Director's order, and evidence. 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 of Worsened Hypertension

The Referee found that claimant's hypertension is compensable as it is related to his compensable left knee condition under ORS 656.005(7)(a)(A). We agree that ORS 656.005(7)(a)(A) applies to this claim, because the hypertension condition is only indirectly related to the compensable injury. See Albany General Hospital v. Gasperino, 113 Or App 411, 414 (1992).

The court has specifically held that, under ORS 656.005(7)(a)(A), "any injury or condition that is not directly related to the industrial accident is compensable only if the major contributing cause is the compensable injury." Hicks v. Spectra Physics, 117 Or App 293, 297 (1992) (emphasis in original); Kephart v. Green River Lumber, 118 Or App 76, 79 (1993) (citing Hicks v. Spectra Physics, supra) (a consequence of an industrial injury is "only compensable if the injury is the major contributing cause."); see also Weyerhaeuser Co. v. Pitzer, 123 Or App 1, 4 (1993) (citing Kephart v. Green River Lumber, supra; Hicks v. Spectra Physics, supra; Albany General Hospital v. Gasperino, supra) ("under ORS 656.005(7)(a)(A), a subsequent condition is compensable if there is 'a compensable injury' and that injury is 'the major contributing cause of the consequential condition.'").

A finding of "major" causation requires that the injury contributes more to the claimed condition than all other causes, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-311 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem, 111 Or App 666 (1992).

The medical evidence indicates that claimant's current hypertension is related to his compensable left knee condition and the attendant claims processing. Dr. Francis, who treats claimant for hypertension, opined that the "accepted injury and its sequellae [sic] including dealing with the insurance carrier and other related people has aggravated the basic tendency to systemic hypertension." (Ex. 17). Dr. Raczka, claimant's treating orthopedist, essentially concurs with Dr. Francis. (Exs. 13, 15). Finally, Drs. Ebersole and Vanderlip, treating psychologist, also opined that the compensable injury and the adversarial interactions with SAIF are causal factors in claimant's hypertension symptoms. (Ex. 16).

Although all physicians indicate that claimant's compensable injury is a contributing factor to his hypertension condition and need for treatment, none of the physicians have stated that the compensable injury is the major contributing cause. On this record, claimant has not established that the compensable injury contributed more to his hypertension that any other factor. "Magic words" are not required to establish the compensability of a claim. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, considering the non-injury factors and the fact that claimant's hypertension condition preexisted the injury, we do not consider the medical opinions sufficient to satisfy the compensability standard.

Consequently, the hypertension condition is not compensable under ORS 656.005(7)(a)(A). See Michael D. Demagalski, 45 Van Natta 2251 (1993) (although the claimant's work injury may have indirectly contributed to his bicycle accident, because the claimant's arm was in a cast as a result of treatment for the compensable injury, the work injury was not the major contributing cause of the left wrist fracture which happened when the claimant fell from his bicycle).

In reaching this conclusion, we acknowledge that claimant would not have been involved in claim processing but for his compensable left knee injury. However, as noted earlier, claimant's hypertension is compensable "only if the major contributing cause is the compensable injury." Hicks v. Spectra Physics, supra, 117 Or App at 297. Inasmuch as the evidence does not support such a conclusion, we are unable to find that claimant's hypertension is a compensable consequence of his industrial injury.

Finally, because the claim for hypertension is not compensable, there are no amounts due and the Referee's penalty and attorney fee award associated with the claim must be reversed.

Sufficiency of the Record Before the Director/Medical Services/Evidence

We adopt that portion of the Referee's order, as reconsidered, which affirmed a Director's order finding that housekeeping services are not reimbursable medical services, with the following supplementation.

Claimant asserts that the Director made no findings of fact concerning the housekeeping services issue and, thus, the Director's order is not supported by substantial evidence. We disagree.

The Director's order relates that Dr. Raczka recommended housekeeping services for claimant because claimant's "limitations in bending, squatting, stooping, and getting to an upright position curtail his ability to perform normal household chores." (Ex. 21-2). This finding mirrors the medical evidence concerning the housekeeping "prescription." (See Ex. 20). Considering the above-quoted findings, we are not persuaded that the order is based on insufficient findings.

On the merits of the "medical services" issue, we are bound by Lorenzen v. SAIF, 79 Or App 751, 752 (1986), which held that compensable medical services include only those "other related services" which are "of the same kind or class as those services specifically enumerated in [ORS 656.245(1)]." In this case, housekeeping help was recommended solely because of claimant's inability to perform household chores. Under these circumstances, we cannot say that housekeeping help is of the same kind or class as those services specifically enumerated in the statute. See ORS 656.245(1)(c). Accordingly, on this record, we conclude, as did the Referee and the Director, that there is no showing that housekeeping services are reimbursable medical services under ORS 656.245. Compare Robert P. Holloway, Sr., 45 Van Natta 2036 (1993), on recon 46 Van Natta 117 (1994) (where housekeeping and other home-based services were expressly intended to assist the claimant in his recovery from surgery, the services were compensable under ORS 656.245(1)(c)).[1]

Finally, we note claimant's contention that the Referee erred in excluding Exhibit 30, a letter from Dr. Raczka to claimant's attorney which was prepared after the Director's order. We need not resolve this question because, even if we considered Dr. Raczka's letter, it would not alter our conclusion that the Director's order should be affirmed.

ORDER

The Referee's order dated June 28, 1993, as reconsidered July 9, 1993, is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's partial denial of claimant's hypertension is reversed. The denial is reinstated and upheld. The Referee's penalty and attorney fee awards associated with the claim for hypertension are reversed. The remainder of the order is affirmed.

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[1] ORS 656.245(1)(c) provides in relevant part:

"Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces, supports and where necessary, physical restorative services. . . ."

In the Matter of the Compensation of
ANDREW B. BAIRD, Claimant
WCB Case Nos. 92-11894 & 92-00144
CORRECTED ORDER ON REVIEW
Lucas & Associates, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

It has come to our attention that our April 13, 1994 Order on Review contains a clerical error. Specifically, although we found that claimant's medically stationary date should be July 22, 1991, the "Order" portion of our decision affirmed "[c]laimant's April 18, 1991 medically stationary date as found by the Notices of Closure and Order on Reconsideration." In the interests of correcting this oversight, we replace the "Order" portion of our April 13, 1994 decision with the following paragraph.

"The Referee's order dated June 9, 1993 is affirmed in part and modified in part. Claimant's July 22, 1991 medically stationary date as found by the Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an approved fee of 25 percent of the "increased" temporary disability benefits created by this order (temporary disability payable between April 18, 1991 and July 22, 1991), not to exceed $3,800. This fee shall be recovered by claimant's attorney in the manner set forth in this order. The remainder of the Referee's order is affirmed."

Accordingly, we withdraw our April 13, 1994 order. As corrected herein, we republish our April 13, 1994 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
CLAUDE R. BAUDER, Claimant
WCB Case Nos. 91-07679 & 90-09225
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Helmsman Management Services, on behalf of the self-insured employer requests review of that portion of Referee Podnar's order that set aside its March 27, 1990 denial of claimant's low back injury claim. On review, the issue is compensability.

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

Claimant filed a claim for a low back injury occurring on November 20, 1989, which the employer denied on March 27, 1990; and a claim for a low back injury or occupational disease occurring on February 4, 1991, which the employer denied on May 14, 1991. The two claims were consolidated for hearing, and the Referee set aside both denials. [Claimant also filed a claim for an August 1992 low back injury which the employer accepted].

On review, the employer challenges only the Referee's decision concerning its March 1990 denial. The employer argues that the November 1989 incident was not an injury because claimant never sought treatment as a result of this event. We disagree.

Relying on treating physician Rabie, the Referee found that the cumulation of claimant's work injuries, including the November 1989 injury, is the major contributing cause of claimant's lumbar degenerative disc disease (DDD); that the DDD was the condition for which treatment was sought; and that the DDD is compensable as an occupational disease. Thus, when claimant sought treatment for his DDD condition, he sought medical treatment for the November 1989 work injury.

The employer does not dispute that claimant's degenerative disc disease is compensable as an occupational disease. Nonetheless, it relies on the contrary opinion of examining physician Wilson for the proposition that the treatment claimant sought in February 1990 was not related to the November 1989 work injury. However, in finding claimant's DDD condition compensable, the Referee rejected Dr. Wilson's opinion. Moreover, the employer's reliance on Dr. Wilson's opinion is inconsistent with its acceptance of the DDD. In any event, as did the Referee, we find that claimant's multiple work injuries, including the November 1989 work injury, were the major contributing cause of claimant's low back condition, i.e., degenerative disc disease.

Consequently, because the November 1989 injury has resulted in an accepted claim for DDD, claimant has established the compensability of his November 1989 work injury claim.

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

ORDER

The Referee's order dated March 9, 1993 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
PATSY M. BRAUGHT, Claimant
WCB Case Nos. 93-08904 & 93-07548
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Garaventa's order which: (1) upheld the SAIF Corporation's denial of her accidental injury/occupational disease claim for toxic exposure; and (2) upheld the SAIF Corporation's denial of her occupational disease claims for her bilateral carpal tunnel and bilateral shoulder conditions. On review, the issues are compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also offer the following summary of the relevant facts.

Employed as a hospital housekeeper, claimant complained of left shoulder pain on September 25, 1992. Dr. Brink, claimant's treating osteopath, diagnosed acute tendonitis and bursitis. Treated with cortisone injections, claimant continued to work.

Claimant returned to Dr. Brink in April 1993 complaining of right shoulder pain, which she later attributed to an alleged incident on April 23, 1993 when she was making a bed at work. Claimant also experienced a return of left shoulder symptoms and was later diagnosed with bilateral carpal tunnel syndrome. Both the bilateral shoulder and bilateral carpal tunnel conditions were denied by SAIF on July 15, 1993.

On January 19 and 20, 1993, claimant and other employees noticed a diesel-like smell of unknown origin. On January 24, 1993, claimant opened a box of garbage bags that emitted a strong odor. Claimant reported that she felt light-headed and that she had developed a pruritic rash on the upper part of her chest, numbness in her lips, hoarseness and a sore throat.

On January 27, 1993, claimant consulted an emergency-room physician, Dr. Eshleman, who diagnosed an allergic reaction. Dr. Eshleman suspected that claimant's rash was a local irritation and "probably an anesthetic effect from the chemical she was exposed to***." (Ex. 2-1).

Dr. Brink examined claimant on February 1, 1993, and reported that claimant's rash had not improved. He continued Dr. Eshleman's prescription of valisone cream for claimant's rash, described as diffusely and deeply red and extending from just beneath the jaw to the suprasternal notch. (Ex. 2-2). On February 10, Dr. Brink diagnosed industrial exposure resulting in alleged hoarseness, laryngitis, bronchitis and bronchospasm. (Ex. 2-3). Subsequently, several physicians, Drs. Pliskin, Defrees, and Rose, linked claimant's pruritic rash to her plastic bag exposure. (Exs. 2-4, 2-5, 2-7).

On referral from Dr. Brink, Dr. Throop, a neurologist, examined claimant on February 14, 1993. (Ex. 4). He noted claimant's history that at least five other employees were reporting similar symptoms, including numbness and rashes. His examination revealed sensory loss over the lips, a rash "which nicely demarcates the exposed area when she would be wearing a blouse" and hoarseness of voice. Dr. Throop concluded that "this must have been some type of contact exposure to aromatics in the plastic bag." Dr. Throop referred claimant to an otolaryngologist, Dr. Olsen, to investigate claimant's vocal cords.

Dr. Olsen found no evidence of laryngeal pathology to explain claimant's hoarseness, which he felt was functional in nature. (Ex. 5). Dr. Olsen speculated that there "may be" some contact dermatitis related to chemical exposure, but that this was outside his area of expertise.

Dr. Rapp, immunologist, examined claimant on referral from Dr. Brink on March 5, 1993. (Ex. 5F). Dr. Rapp diagnosed "questionably" organic fume exposure and "doubtful" latex allergy. He referred claimant to a clinical toxicologist, Dr. Burton, who, along with Dr. Anker, another toxicologist, examined claimant on March 12, 1993. (Ex. 8).

Drs. Anker and Burton diagnosed probable anxiety disorder associated with recurrent episodes of hyperventilation and a rash in sun-exposed areas not of toxic origin. They further stated that it was very unlikely, and that there was no evidence to suggest, that claimant's symptoms and clinical findings were consistent with an allergic reaction. Concluding that claimant's symptoms were most likely functional in nature, Drs. Anker and Burton opined that they probably were the result of an anxiety disorder and triggered by odor or the sight of the plastic bag. Both doctors found it significant that claimant would report symptoms merely being in the same room with a plastic bag and that her symptoms had not abated even when she was removed from exposure.

Dr. Rapp commented subsequently that there was no objective data or "any double-blind test" that could be devised to clearly prove whether or not claimant was having a reaction to odors associated with plastic bags. (Ex. 8A). On June 24, 1993, SAIF denied the toxic exposure claim on the grounds that claimant's work activity was not the major contributing cause of either a work-related injury or occupational disease. (Ex. 9).

SAIF later arranged an examination with dermatologists, Drs. Smith and Storrs, from Oregon Health Sciences University. Their examination revealed evidence of sun-damaged skin on claimant's neck and face, but her dermatological examination was otherwise normal. (Ex. 10). A patch test was also conducted, using a sample garbage bag provided by claimant, but it was negative. Unable to document a causal relationship between claimant's work exposure and her current complaints, the doctors noted that an investigation had determined that hydraulic fluid had leaked into the machinery that pressed the plastic garbage bags. Drs. Smith and Storrs also wrote that many people have "flushing" reactions to strong odors or other sensory cues mediated by the autonomic nervous system. They could not determine whether this was the case with claimant, but such reactions were "common" in the general population.

SAIF arranged yet another examination with an occupational medicine physician, Dr. Berney, on August 27, 1993. (Ex. 11). Dr. Berney related that claimant was one of several housekeepers he had examined in relation to the alleged toxic exposure. Dr. Berney explained that he took a public health and epidemiological approach to the causation issue. He further explained that this entailed looking at the probabilities of an event occurring by chance in a population at risk, rather than looking at physical findings and diagnoses in isolated individuals.

Having spoken to the employer's employee health nurse and safety manager, Dr. Berney determined that 10 of 17 employees in the housekeeping department reported symptoms during two acute exposures in January 1993 and February 1993. Noting that the reported symptoms were consistent, Dr. Berney opined that the attack rate of 59 percent was "very suggestive" of a nonrandom event and that there was a "very high probability" of a significant relationship between the work exposure and the disease. Dr. Berney discounted the possibility of a mass psychogenic illness because supervisory personnel, such as the employee health nurse, housekeeping supervisor and safety manager, developed acute symptoms on exposure to the plastic bags.

CONCLUSIONS OF LAW AND OPINION

Bilateral CTS and Bilateral Shoulder Conditions

Finding no medical opinion that persuasively implicated claimant's work activities as the major contributing cause of her bilateral CTS and shoulder conditions, the Referee concluded that claimant had failed to establish that these conditions were compensable occupational diseases. The Referee, accordingly, upheld SAIF's denial of these conditions. We agree that the medical evidence is insufficient to satisfy claimant's burden of proof.

Neither party disputes the Referee's analysis of the carpal tunnel and shoulder conditions as occupational disease claims under ORS 656.802(2). There are five relevant medical opinions: those of Dr. Brink, claimant's attending physician; Drs. Ellison and Corsolini, consulting physicians; and Drs. Radecki and Woolpert, SAIF's examining physicians. Dr. Ellison, who examined claimant on referral from Dr. Brink, opined that claimant's employment was the major contributing cause of her right shoulder and carpal tunnel conditions. (Ex. 11). However, Dr. Ellison provided no explanation for his conclusion. Accordingly, we give his opinion little weight. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Corsolini also opined that claimant's work activity was the major contributing cause of claimant's right shoulder and carpal tunnel conditions. (Ex. 8). However, Dr. Corsolini subsequently and without explanation concurred with Dr. Radecki's medical opinion that claimant's carpal tunnel syndrome was not related to her employment, but rather to factors such as heredity, weight and aging. (Exs. 9, 14.). Dr. Corsolini also concurred with Dr. Radecki's comments that non-organic factors were contributing to both the carpal tunnel and shoulder conditions. Given his significant reversal of opinion, we do not accord a great deal of weight to Dr. Corsolini's initial statements concerning the causation of both the shoulder and carpal tunnel conditions.

While Dr. Brink also opined that claimant's employment activities were the major contributing cause of her carpal tunnel and shoulder conditions, his opinion was also given with little explanation. (Ex. 13). Although we generally give the opinion of the treating physician considerable weight, See Weiland v. SAIF, 64 Or App 810 (1983), under these circumstances, we find a persuasive reason not to do so. Moe v. Ceiling Systems, supra.

The remaining medical opinions addressing the causation issues do not support the compensability of the denied conditions. As previously noted, Dr. Radecki opined that claimant's carpal tunnel condition was not employment related. He also could not link claimant's shoulder complaints to her work to a degree of medical probability and emphasized the impact of non-organic factors in claimant's pain complaints. (Ex. 9). Dr. Woolpert also identified significant non-organic pain factors in claimant's bilateral carpal tunnel and bilateral shoulder complaints. (Ex. 12). He specifically concluded that claimant's carpal tunnel condition was idiopathic and that claimant's right shoulder condition represented an independent degenerative process. Claimant's left shoulder symptoms, according to Dr. Woolpert, were due to non-organic factors.

In contrast to the conclusory reports of Drs. Ellison and Brink and the contradictory reports of Dr. Corsolini, the medical opinions of Drs. Radecki and Woolpert are thorough, well-reasoned and consistent. For these reasons, they are the most persuasive. See Somers v. SAIF, 77 Or App 259 (1986). We, therefore, conclude that claimant has failed to satisfy her burden of proving that her bilateral carpal tunnel and bilateral shoulder conditions are compensable.

Toxic Exposure

The Referee analyzed the toxic exposure claim as one for accidental injury because it involved discrete incidents with immediately reported symptoms. The Referee further reasoned that Dr. Berney's analysis of the causation issue failed to consider the medical probability of a causal connection in this particular case and to address the impact of the functional component on the claim. The Referee then concluded that the great weight of the medical evidence established no causal connection between claimant's work exposure and her symptomatology. Accordingly, the Referee upheld the denial of claimant's toxic exposure claim.

Claimant contends that, in analyzing the causation issue, the Board should rely on Dr. Berney's epidemiological analysis and the medical opinions of the physicians who initially treated claimant. We agree.

The parties do not dispute that the toxic exposure claim should be analyzed as an accidental injury. We agree, given that claimant's alleged exposure to toxic chemicals occurred during a discrete period. See Valtinson v. SAIF, 56 Or App 184, 188 (1982). Accordingly, claimant must prove that her work exposure is a "material contributing cause" of the symptoms for which she sought treatment. See Mark N. Weidle, 43 Van Natta 855 (1991). In addition, because of claimant's unusual reaction to exposure to plastic garbage bags and because of other potential causes of claimant's symptoms, we find the causation issue to be medically complex. Accordingly, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The Referee was more persuaded by the medical opinions of Drs. Olsen, Anker, Burton, Smith, and Storrs than the opinion of Dr. Berney. In particular, the Referee found Dr. Berney's opinion lacking because it did not address the functional component to claimant's complaints and did not consider the circumstances of claimant's particular case. Unlike the Referee, we do not believe that these weaknesses seriously undermine the persuasiveness of Dr. Berney's opinion, which was solicited by SAIF.

While he acknowledged that causation in epidemiology is difficult to prove, Dr. Berney discussed the claim with representatives of the employer, and he was aware of the extent to which other employees were affected by the chemical exposure. SAIF does not dispute that the plastic bags in question were contaminated with some kind of chemical. Nor does SAIF seriously question that other employees, including supervisory personnel, reported similar symptoms, which included rashes and numbness. In light of this, we find Dr. Berney's opinion, based on an accurate history, as well as on an epidemiological and public health approach to causation, to be persuasive.

We are mindful that Dr. Brink reported that claimant was experiencing symptoms of itching and dermatitis in September 1993, which claimant stated were worse with "nerves." (Ex. A19). However, the area affected at that time was in a different location (under the breasts). Moreover, the fact that a majority of housekeeping employees also reported complaints similar to claimant's after the January and February 1993 exposures also provides support for our conclusion that claimant's current symptoms are not a continuation of prior non-work related complaints.

We also find support for Dr. Berney's opinion in other medical reports more contemporaneous with claimant's exposure. For instance, on February 10, 1992, Dr. Brink related claimant's symptoms to "industrial exposure." (Ex. 2-3). Drs. Rose, Pliskin and Defrees all linked claimant's complaints to claimant's work exposure. (Exs. 2-4, 2-5, 2-7). Dr. Throop stated on February 15, 1993 that there "must have been some type of contact exposure to aromatics in the plastic bag." (Ex. 4).

In contrast to the Referee, we do not find the medical opinions of the physicians with a contrary position to be more persuasive than Dr. Berney. While Dr. Olsen attributed claimant's reported hoarseness to functional problems, he conceded that he lacked the expertise to address the etiology of claimant's rash. (Ex. 5). Unlike Dr. Berney, Drs. Burton and Anker failed to address the causal implications of other employees reporting symptoms similar to claimant's. In addition, there is no indication that they discussed the claim with employer representatives or received any documents from the employer, as did Dr. Berney. Dr. Berney also had the advantage of examining other affected employees.

Finally, Drs. Storrs and Smith confirmed that the plastic bags to which claimant was exposed were probably contaminated. While they could not link claimant's symptoms to the work exposure from a dermatological standpoint, Drs. Smith and Storrs suggested that claimant's reaction to the plastic bags could be explained by a "flushing reaction" common to the general population. (Ex. 10).

In conclusion, on reviewing the totality of the medical evidence, we find that Dr. Berney's is the most persuasive medical opinion addressing the causation issue. See Somers v. SAIF, supra. While Dr. Berney's opinion is not without weaknesses, we do not consider the concerns expressed by the Referee to seriously undermine its persuasiveness. While the question is a close one, we find that the preponderance of the most persuasive medical evidence supports the compensability of claimant's toxic exposure claim. Accordingly, we find that claimant's work exposure is a material contributing cause of her symptoms and need for medical treatment. We, therefore, set aside SAIF's denial of claimant's toxic exposure claim.

Claimant's counsel is entitled to attorney fees for services at hearing and on review concerning the compensability of claimant's toxic exposure claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review regarding the toxic exposure claim is $3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 28, 1993 is reversed in part and affirmed in part. That portion which upheld SAIF's denial of claimant's toxic exposure claim is reversed. SAIF's June 4, 1993 denial is set aside and the claim is remanded to SAIF for processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the toxic exposure claim, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by SAIF.

In the Matter of the Compensation of
BEVERLY L. CARDIN, Claimant
WCB Case No. 93-02836
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that affirmed an Order on Reconsideration which did not award any permanent disability. Claimant seeks an unscheduled permanent disability award and, alternatively, requests remand to either the Appellate Unit to "complete" the arbiter's examination or to the Referee to appoint a medical examiner. On review, the issues are remand and extent of unscheduled permanent disability.

We deny the motion to remand and adopt and affirm the Referee's order with the following supplementation.

Claimant requested reconsideration of a Determination Order which awarded no permanent disability. A medical arbiter, Dr. Stanford, measured claimant's cervical range of motion, but reported that his findings were unreliable owing to claimant's marked pain behavior and almost hysterical fear of moving her neck. (Ex. 12). The Order on Reconsideration did not award any permanent disability for lack of objective evidence of permanent impairment. (Ex. 13).

The Referee, noting Dr. Stanford's comments regarding the reliability of his range of motion measurements, declined to use the findings in determining whether claimant had permanent impairment. Finding no objective evidence of permanent impairment, the Referee affirmed the reconsideration order.

Claimant contends that she is entitled to an impairment rating based on the values measured by the medical arbiter. Alternatively, claimant asks that we remand for another arbiter's examination to obtain valid measurements of range of motion. She cites Department Bulletin 239 (August 2, 1991) as requiring the Director to reexamine a claimant when valid range of motion measurements cannot be obtained.

We do not consider issues raised for the first time on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Because claimant did not raise her remand request at hearing, we decline to consider it on review. Moreover, even if we had considered this issue, we would deny the request.

Although we have the authority to remand to the Director for the adoption of temporary rules to address permanent impairment not covered by the disability standards, see Gallino v. Courtesy-Buick-GMC, 124 Or App 538 (1993), claimant makes no contention that the standards do not adequately address her permanent impairment. Moreover, we have previously held under similar circumstances that we will not remand a claim for a supplemental arbiter's examination. Enriqueta M. Restrepo, 45 Van Natta 752 (1993).

As in Restrepo, the Department in this case accepted the medical arbiter's report and relied on it to determine the extent of claimant's unscheduled permanent disability. The Department did not find the arbiter's report incomplete and did not direct the arbiter to perform a supplemental examination. Under these circumstances, there is no basis to remand. Enriqueta M. Restrepo, supra.

In addition, we do not find that the Department acted in violation of its rules. Bulletin 239 does not refer to medical arbiter examinations, but instead to attending physician closing examinations and reports. Moreover, the version of Bulletin 239 to which claimant refers was superseded in July 1992. Even assuming the current version applies to medical arbiter examinations, it does not make reexaminations mandatory when inconsistencies are apparent in range of motion testing.

In her reply brief, claimant requests for the first time that this matter be remanded to the Referee for the appointment of a medical examiner. Inasmuch as claimant did not seek appointment of a medical examiner at hearing, we decline to consider her request on review. See Stevenson v. Blue Cross of Oregon, supra.

In conclusion, we find a preponderance of medical evidence does not support a finding of permanent impairment due to reduced range of motion. Claimant's treating physician, Dr. Flaming, released claimant to regular work without restrictions (Ex. 8) and the medical arbiter considered his impairment measurements to be unreliable. We, therefore, affirm the Referee's order which declined to award claimant permanent disability.

ORDER

The Referee's order dated July 30, 1993 is affirmed.

In the Matter of the Compensation of
JOHN L. DESMOND, Claimant
WCB Case Nos. 92-16425, 92-15347 & 92-15694
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Schultz's order which: (1) upheld the SAIF Corporation's partial denials of claimant's cervical and thoracic injuries sustained in motor vehicle accidents while enrolled in a vocational training program; and (2) upheld Portland Community College's denials of the same injuries. On review, the issues are compensability and coverage under ORS 656.046.

We adopt and affirm the Referee's order with the following supplementation.[1]

Claimant sustained a compensable injury on December 6, 1988, while employed by SAIF's insured. Claimant subsequently entered a vocational training program coordinated by the self-insured employer, Portland Community College. During the course of his training in telephone sales and communication, claimant sustained cervical and thoracic injuries in two separate motor vehicle accidents. Both SAIF and Portland Community College denied compensability and responsibility.

The Referee held that claimant's injuries were not compensable under Kephart v. Greenriver Lumber Co., 118 Or App 76 (1993). Claimant does not dispute that Kephart is controlling as to the claims against SAIF. However, claimant asserts that Portland Community College is responsible for his injuries under ORS 656.046(1), because he was a trainee participating in a "college directed vocational project." Pursuant to this statute, such trainees are considered to be workers of the college and subject to ORS 656.001 to 656.794.

ORS 656.046(8) provides:

> "As used in this section, 'college directed vocational education project' means an assigned on-campus or off-campus project that is a component of a program approved by the college board or the operating procedures of the State Board of Education and involves work that provides practical experience beyond the initial instruction and demonstration phases, performed outside the college classroom or laboratory environment and requiring substantial hands-on participation by trainees. Such projects are further limited to logging, silvicultural thinning, slash burning, fire fighting, stream "enhancement, woodcutting, reforestation, tree surgery, construction, printing and manufacturing involving formed metals." (Emphasis added).

Even assuming claimant met the other requirements of a "college directed vocational education project," this statute would still be inapplicable because telephone communication and sales are not among the projects listed in ORS 656.046(8). Therefore, we agree with the Referee's determination that claimant was not a subject worker of Portland Community College. Accordingly, we affirm the Referee's decision on this issue.

ORDER

The Referee's order dated July 22, 1993 is affirmed.

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[1] Member Gunn, as the Referee was, is bound by stare decisis to follow Kephart supra. But that decision allows a group of workers to enter vocational training without recourse for any injuries sustained in that training. It would appear to add this group of workers to the ranks of newspaper carriers. See ORS 656.075. This does not strike me as substantial justice.

In the Matter of the Compensation of
ALICE I. DOWN-JONES, Claimant
WCB Case No. 92-15654
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Holtan's order which: (1) upheld the insurer's denial of claimant's current left knee condition; (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial; and (3) awarded a $1,200 attorney fee for prevailing against the insurer's denial of claimant's left knee injury claim. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On November 1, 1992, claimant did not seek treatment for chondromalacia, and Dr. Botkin did not diagnose chondromalacia at that time. (See Exhibit 16-17). Rather, Dr. Botkin diagnosed patellar bursitis and arthritis. (Ex. 1).

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant was treated by Dr. Botkin, family medicine, for a painful left knee condition on November 1, 1992. (Ex. 1). Dr. Botkin noted swelling and crepitus in claimant's patella, and diagnosed patellar bursitis and arthritis. (Exs. 1; 16-12). On November 12, 1992, claimant returned to Dr. Botkin after having fallen on her left knee at work.

The Referee stated that the employer conceded at the close of hearing that claimant's prepatellar bursitis, caused by the fall at work, was compensable. The parties do not dispute that conclusion.

The Referee found that claimant's November 11, 1992 left knee work injury had combined with claimant's preexisting knee condition, and concluded that ORS 656.005(7)(a)(B) applied in determining whether claimant's resultant knee condition was compensable. We agree with the Referee's application of ORS 656.005(7)(a)(B).

The Referee further found that the preexisting condition had symptomatically worsened after the work injury. However, he concluded that, because the preexisting condition had not pathologically worsened, claimant's resultant condition was not compensable under ORS 656.005(7)(a)(B). We disagree for the following reason.

In order to find a "resultant condition" compensable pursuant to ORS 656.005(7)(a)(B), the evidence must show that the work injury is and remains the major contributing cause of claimant's disability or need for treatment. Here, the uncontroverted medical evidence shows that claimant's work injury remained the major contributing cause.

Dr. Botkin, claimant's treating physician, saw claimant for pain in her left knee twelve days prior to her work injury. He noted crepitus in claimant's patella, and swelling in the knee capsule. His diagnosis was patellar bursitis and arthritis. (Ex. 1). Claimant testified that when she began taking the medication prescribed by Dr. Botkin for the arthritis, her knee pain subsided after approximately a week. (Tr. 46).

When claimant returned after her fall at work, Dr. Botkin noted that the patella was more tender in the same area as he noted during his previous examination on November 1, 1992. (Exs. 5, 16-16). He took claimant off work until November 16, 1992.

By November 16, 1992, when Dr. Botkin next saw claimant, her condition had worsened. Dr. Botkin referred claimant to Dr. Hoda, orthopedist. Dr. Hoda diagnosed "prepatellar bursitis, traumatic," and "possible traumatic chondromalacia, inferior pole of the patella." (Ex. 6B).

Dr. Botkin is the only physician to offer an opinion concerning the cause of claimant's knee condition after her work injury. On two different occasions, Dr. Botkin stated that the major contributing cause of claimant's condition after her fall, which required treatment and resulted in disability, was the fall at work on November 11, 1992. (Exs. 15, 16-29).

Accordingly, after conducting our review of the evidence, we are convinced that this record satisfies the requirements of ORS 656.005(7)(a)(B). Claimant has met her burden of proving that her November 11, 1992 work injury is the major contributing cause of her "resultant condition."

Penalty and Attorney Fee

The Referee concluded that a penalty for an unreasonable denial was not warranted because the insurer had legitimate doubt as to compensability due to claimant's treatment for a preexisting condition. We disagree.

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 on 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. Hutchinson v. Fred Meyer, Inc., 118 Or App 288 (1993).

Here, the insurer issued a denial on November 24, 1992 which stated, in part, "that insufficient evidence exists to justify a contention that your condition diagnosed as contusion of the left knee is the result of either an injury or disease precipitated by your occupational exposure at [the employer]." (Ex. 7).

There is no evidence in the record that claimant did not experience a fall on her knee at work on November 11, 1992. After claimant slipped and fell, two supervisors helped claimant up and escorted her to the nurses station where another employee gave claimant a bandage and some ice. (Tr. 54-57).

Furthermore, Dr. Botkin's report the day after the fall at work diagnosed left knee contusion. (Ex. 3). Even though contemporaneous medical reports in the record at the time of the denial (the 801 form (Exhibit 2), an 827 from Dr. Botkin (Exhibit 3), and the initial report from Dr. Hoda (Exhibit 6B)) indicate that claimant has preexisting arthritis in her left knee, the denial specifically denies that claimant suffered an injury at work which caused a left knee contusion. It did not state that a preexisting condition was responsible for claimant's knee problem.

Accordingly, based on the record before us, we find nothing that would have provided the insurer with a legitimate doubt concerning the compensability of claimant's left knee injury at the time of the denial. Consequently, we assess a penalty for the insurer's unreasonable denial equal to 25 percent of the temporary disability benefits and outstanding medical bills due under the left knee injury claim through February 25, 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).

Amount of Attorney Fee at Hearing

Claimant contends that the $1,200 attorney fee awarded by the Referee for the insurer's concession at the end of the hearing that claimant's fall caused prepatellar bursitis was insufficient. After considering the factors set forth in OAR 438-15-010(4), we find that the Referee's award for claimant's finally prevailing over the insurer's denial of claimant's left knee injury claim was reasonable.

Attorney Fee

Because we have reversed that portion of the Referee's order that found claimant's current knee condition not compensable, claimant is entitled to an assessed attorney fee. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the current knee condition is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's appellant's brief and reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 21, 1993 is reversed in part and affirmed in part. That portion of the order which upheld the insurer's partial denial of claimant's current left knee condition is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,000 to be paid by the insurer. For the insurer's unreasonable refusal to pay compensation, claimant is awarded a penalty in an amount equal to 25 percent of compensation due under the left knee injury claim at the time of hearing, with one-half to be paid to claimant's attorney. The remainder of the order is affirmed.

April 20, 1994 Cite as 46 Van Natta 775 (1994)

In the Matter of the Compensation of
GEORGE O. HAMLIN, Claimant
WCB Case No. 93-02757
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our March 24, 1994 Order on Review which found that claimant has the Residual Functional Capacity (RFC) to perform work in the "medium/light" category. Claimant contends that his maximum RFC is in the "light" category, and that his adaptability factor should be adjusted accordingly.

We withdraw our March 24, 1994 order for reconsideration. After consideration of claimant's motion for reconsideration, as well as the SAIF Corporation's memorandum in opposition to claimant's motion, we continue to find that claimant's RFC is in the "medium/light" category.

Claimant contends that the job to which he was released--driving a city transit bus, but limited only to buses with power steering--is in the "light" strength category. Therefore, he contends that his RFC should be "light." We disagree.

The standards provide that a worker's RFC is the greatest capacity evidenced by either the attending physician's release, the preponderance of medical opinion, or the strength of the job to which claimant returned. Former OAR 436-35-270(3)(d) (WCD Admin. Order 6-1992, effective March 13, 1992). Claimant's attending physician released him to his job as a bus driver, which has a strength value of "medium." The only limitation identified by his attending physician was a permanent restriction to operating only buses with power steering. (See Exs. 3D, 12). We interpret the attending physician's release as a release to work in the "medium" strength category, but with a restriction that prevents claimant from performing the full range of requirements of his "medium" strength job as bus driver. Accordingly, pursuant to former OAR 436-35-310(3), we conclude that claimant's RFC is "medium/light," based on his attending physician's release.

Even if we were to find that the job to which claimant returned was properly classified as "light," that finding alone would not determine claimant's RFC. We have found, based on his attending physician's release, that claimant's RFC is "medium/light." Pursuant to former OAR 436-35-270(3)(d), claimant's RFC is determined by the greatest capacity shown by the appropriate evidence. Therefore, we adhere to our prior determination and continue to find that claimant's RFC is "medium/light."

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 24, 1994 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
MARK S. LILLIBRIDGE, Claimant
WCB Case No. 93-01844
SECOND ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

On April 6, 1994, we issued an Order on Reconsideration which adhered to our March 10, 1994 order that modified a Referee's order that had reduced claimant's unscheduled permanent disability award from 26 percent (83.2 degrees), as granted by an Order on Reconsideration, to 23 percent (73.6 degrees). Specifically, we reduced claimant's award to 15 percent (48 degrees). We have now received the SAIF Corporation's "Supplemental Reconsideration Request," in which SAIF seeks permission to "offset any overpayments as allowed by law." We treat SAIF's submission as a motion for reconsideration of our prior decisions.

This case arose from SAIF's request for hearing from an Order on Reconsideration which had awarded claimant 26 percent unscheduled permanent disability, whereas a Notice of Closure had awarded no permanent disability. At the hearing, claimant represented (without objection from SAIF) that SAIF had not paid any of the 26 percent award. (Tr. 5). Following issuance of the Referee's order (which reduced claimant's award from 26 percent to 23 percent), SAIF requested Board review, noting that payment of the compensation granted by the Referee's order would be stayed under ORS 656.313.

In light of such circumstances, this record does not support a conclusion that SAIF has paid permanent disability beyond the 15 percent unscheduled award granted by our order. In any event, we decline to consider SAIF's request because this "offset" issue was neither raised at hearing nor on review. Finally, if SAIF wishes to seek authorization to recover any overpayment created by our prior order from any future permanent disability award, that is a matter for another proceeding, not this proceeding.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we republish our April 6, 1994 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
DAVEY L. ODLE, Claimant
WCB Case No. 93-03266
ORDER ON REVIEW
Neil Jackson & Associates, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

The SAIF Corporation requests review of Referee Mills' order that directed it to pay claimant's attorney an "out-of-compensation" fee following SAIF's payment to claimant of additional benefits. On review, the issue is attorney fees.

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

In a prior proceeding, claimant's claim was determined to be compensable. His counsel was the same attorney who presently represents him in this proceeding.

Although SAIF paid temporary disability for the period following the October 8, 1991 Opinion and Order in the prior proceeding, it did not provide such benefits before that date. Claimant's attorney filed a request for hearing raising entitlement to temporary disability before October 8, 1991. An executed retainer agreement accompanied the request. The letter accompanying the request for hearing also indicated that SAIF had been sent copies of the request for hearing and retainer agreement.

SAIF subsequently paid the entire amount of temporary disability benefits to claimant without providing an "out-of-compensation" attorney fee to claimant's counsel. The Referee, relying on Nancy E. O'Neal, 45 Van Natta 1490, on recon 45 Van Natta 1591, on recon 45 Van Natta 2081 (1993), ordered SAIF to pay claimant's attorney a percentage of such benefits and, recognizing that the award created an overpayment, authorized an offset against future awards of permanent disability.

In Nancy O'Neal, supra, the claimant's attorney filed a "supplemental" request for hearing contending that the claimant was entitled to additional temporary disability because SAIF had not applied the proper rate for the prior award. The carrier had previously received the claimant's executed retainer agreement as well as a copy of the "supplemental" hearing request. After recalculating the rate of temporary disability, the carrier paid the claimant increased benefits without informing the claimant's attorney of its action or paying a portion of the increased compensation to counsel.

On the basis that the carrier was aware of the claimant's representation and the claimant's attorney had taken the only available action to secure his receipt of an attorney fee, the Board ordered the carrier to pay the "out-of-compensation" fee directly to the claimant's attorney and recover the resulting overpayment against any future permanent disability awards. 45 Van Natta at 2083-84.

Subsequently, we issued our order in Jane A. Volk, 46 Van Natta 681 (1994). In Volk, the employer paid 20 percent permanent disability awarded by a Determination Order. On reconsideration, the award was reduced to 11 percent. The claimant requested a hearing. The parties then entered into a stipulation which reinstated the Determination Order's award of 20 percent permanent disability. The parties, however, litigated the issue of the claimant's attorney's entitlement to an attorney fee.

We first found that, because the claimant's attorney's efforts had resulted in a reinstatement of the Determination Order, he was entitled to an "out-of-compensation" attorney fee. However, relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), we further found that an order by the Board to the employer to pay the fee created an improper overpayment. Therefore, we delineated an alternative method for recovery by the claimant's counsel of the attorney fee. 46 Van Natta at 683-684.

Our order further found that such reasoning was not inconsistent with the holding in Nancy O'Neal, supra. Although conceding that an overpayment also was created in that case, we found that, because it was necessitated by the carrier's unilateral action after a request for hearing had been filed, the overpayment essentially was created by the carrier, not by the Board. Id. at 685-686.

Based on the facts of this case, we find that Nancy O'Neal, rather than Jane A. Volk, is applicable to this case. Like counsel in O'Neal, claimant's attorney took the only available action he could to obtain the fee by providing a copy of the retainer agreement to SAIF when he filed the request for hearing. There is no question that SAIF was aware that claimant was represented by counsel at the time it paid the additional temporary disability to claimant. Not only did claimant's attorney also represent him in the prior proceeding against SAIF, but the record shows that counsel participated in subsequent negotiations with SAIF to obtain the additional benefits. (Ex. 3-3).

Therefore, we direct SAIF to pay the "out-of-compensation" attorney fee to claimant's counsel. Nancy O'Neal, supra. Under the circumstances of this case, SAIF, rather than this forum, has created the resulting overpayment. Jane A. Volk, supra. SAIF is authorized to recover the overpayment against any future permanent disability awards.

Inasmuch as the issue on review solely concerns attorney fees, there is no entitlement to an award for services on review. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated August 31, 1993 is affirmed.

In the Matter of the Compensation of
PEARL M. PADGETT, Claimant
WCB Case No. 92-14240
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Hazelett's order that affirmed an Order on Reconsideration that affirmed a Notice of Closure which awarded 17 percent (54.4 degrees) unscheduled permanent disability for a cervical and thoracic 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 exception and supplementation. We do not adopt the Referee's last ultimate finding of fact.

The parties stipulated that, regarding the issue of the extent of unscheduled permanent disability, only the adaptability value was in dispute. (Tr. 19-20). The parties stipulated that the other values listed in the Notice of Closure worksheet were correct. Id. The values stipulated to are: age (1), education (5), and impairment (5 percent). (Ex. 8-3, Tr. 19-20).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Hearings Division was without jurisdiction to consider the extent of claimant's unscheduled permanent disability because claimant had not raised that issue in her request for reconsideration of the insurer's July 30, 1992 Notice of Closure. In reaching this conclusion, the Referee relied, in part, on our holding in Raymond L. Mackey, 45 Van Natta 776 (1993).

Subsequent to the Referee's order, we issued our decision in Darlene K. Bentley, 45 Van Natta 1719 (1993). In Bentley, we disavowed our Mackey decision, 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 in rating permanent disability. Id. Accordingly, claimant was not precluded from challenging, for the first time at hearing, the adaptability value used to rate her disability.

Dr. Flanagan, M.D., a consulting physician, performed claimant's closing examination on July 2, 1992. (Ex. 7). At hearing and on review, claimant argues that Dr. Flanagan's October 13, 1992 physical capacities report should be used to determine her adaptability value. (Ex. 11). Although the Referee admitted Exhibit 11, he determined that it was relevant and material only for the issue of premature closure, relying on his reasoning that claimant could not raise the issue of adaptability for the first time at hearing. As discussed above, claimant may raise the adaptability issue at hearing. Furthermore, because we find the record fully developed, we proceed to review the adaptability issue.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

Here, claimant does not dispute the Referee's conclusion that she became medically stationary as of March 20, 1992. Furthermore, since claimant's claim was closed by a July 30, 1992 Notice of Closure, the standards set forth in WCD Admin. Order No. 6-1992 apply in rating her disability.

At hearing, the parties agreed that only the adaptability value was in dispute and stipulated that the remaining values used in the Notice of Closure worksheet to rate claimant's unscheduled permanent disability were correct. (Tr. 19-20, Ex. 8-3). Thus, the parties stipulated to the following values: age (1), education (5), and impairment (5 percent). Id.

Although we have determined that claimant may raise the issue of her adaptability value at hearing, that determination in and of itself does not resolve the issue of whether Dr. Flanagan's October 13, 1992 report is relevant to the determination of her adaptability value.

The extent of a worker's permanent disability is evaluated by referees and the Board as of the date of the Reconsideration Order. ORS 656.283(7); 656.295(5). We have determined that, although ORS 656.283(7) and 656.295(5) do not provide a clear statutory limitation on medical evidence concerning a worker's permanent disability, they affect the relevancy of evidence that does not address a worker's condition at the pivotal "rating date" (the date of the reconsideration order). Gary C. Fischer, 46 Van Natta 60 (1994).

Here, Dr. Flanagan's report regarding claimant's physical capacities was not issued until October 13, 1992, a week after the October 6, 1992 Order on Reconsideration issued. However, for the following reasons, we find Dr. Flanagan's report relevant to claimant's physical capacities at the time of the reconsideration order.

The parties stipulated that Dr. Flanagan examined claimant one time, in July 1992, and that he subsequently completed a physical capacities form in October 1992. Furthermore, because no medical reports were issued regarding claimant's condition subsequent to the issuance of the October 6, 1992 Order on Reconsideration, Dr. Flanagan could not have relied on any such reports in determining claimant's physical capacity. Therefore, although dated October 13, 1992, Dr. Flanagan's physical capacities evaluation necessarily related to claimant's condition at the July 2, 1992 examination, which occurred after claimant became medically stationary on March 20, 1992 and before the October 6, 1992 reconsideration order. Consequently, we find Dr. Flanagan's physical capacities evaluation relevant to claimant's condition at the time of the reconsideration order. Furthermore, we note that Dr. Flanagan provides the only evidence of claimant's physical capacities subsequent to her becoming medically stationary.

The adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity (RFC) at the time of determination. Former OAR 436-35-310(1). Claimant was employed as a dishwasher at the time she was injured, which has a strength demand of medium. (DOT 318.687-010, kitchen helper). At the time of his July 2, 1992 closing evaluation, Dr. Flanagan described claimant's physical capacity only as "capable of modified work." (Ex. 7-4). However, Dr. Flanagan's October 13, 1992 report lists limitations on lifting and carrying that are within the medium/light range with restrictions on stooping/bending, crouching, crawling, kneeling, twisting, climbing, and reaching. (Ex. 7-4). These limitations give claimant a RFC of light. OAR 436-35-270(3)(e); 436-35-310(3) and (4). Comparing claimant's prior strength of medium to her RFC of light results in an adaptability factor of 3. OAR 436-35-310(3).

We now assemble the factors to determine claimant's permanent disability. Adding the age (1) and education (5) factors results in a value of 6. Former OAR 436-35-280(4). That value is then multiplied by the adaptability factor of 3, resulting in a value of 18. Former OAR 436-35-280(6). That product is then added to the impairment value of 5, resulting in an award of 23 percent unscheduled permanent disability under the standards.

ORDER

The Referee's order dated June 10, 1993 is modified. In addition to the 17 percent (54.4 degrees) unscheduled permanent partial disability awarded by the Notice of Closure, as affirmed by the Order on Reconsideration, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, for a total award to date of 23 percent (73.6 degrees) unscheduled permanent partial disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly by the insurer to claimant's attorney.

In the Matter of the Compensation of
ROBERT J. RADOSTITZ, Claimant
WCB Case No. 92-04656
ORDER ON REVIEW
Eileen G. Simpson, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The insurer requests review of those portions of Referee Black's order that: (1) set aside the insurer's denial of claimant's aggravation claim for his low back condition; and (2) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable claims processing. On review, the issues are aggravation and penalties and attorney fees.

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

On review, the insurer argues in support of a finding that the May 7, 1992 Order on Reconsideration constituted claimant's last arrangement of compensation. The resolution of this dispute is controlled by our recent holding in Lindon E. Lewis, 46 Van Natta 237 (1994), which issued subsequent to the Referee's order.

In Lewis, we concluded that our prior reliance on a claimant's "last opportunity to present evidence" regarding his condition (see Grace M. Nyburg, 44 Van Natta 1875 (1992)) was ill-suited for conducting an aggravation analysis under the current statutory scheme, which provides for mandatory reconsideration by the Department. Instead, we held that evidence regarding the claimant's medically stationary condition up to and including the last award or arrangement of compensation that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1).

Here, as in Lewis, claimant has asserted that his condition worsened during the reconsideration proceeding. Accordingly, claimant is required to prove that his compensable condition worsened since the February 1992 Notice of Closure (the last award or arrangement of compensation prior to the alleged worsening).

Consequently, we find that, in determining whether the compensable condition had worsened, the Referee correctly considered the evidence describing claimant's medically stationary condition at or before the February 1992 Notice of Closure, the last time claimant was medically and legally determined to be medically stationary. See Lindon E. Lewis, supra. We also agree with the remainder of the Referee's "Conclusions of Law and Reasoning," and we adopt his order in its entirety.

Claimant's counsel 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 a reasonable assessed attorney fee for claimant's counsel's services on review concerning aggravation is $1,000. In reaching this conclusion, we have considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated May 11, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
DENNIS F. SCHWAB, Claimant
WCB Case No. 92-15276
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Peterson's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in 1976. In February 1991, claimant became a "power scheduler." He was often required to work extended hours.

Between April 1991 and March 1992, the Trojan plant shutdown made claimant's job more difficult and increased his workload. In May 1992, the employer's Boardman plant shutdown again increased claimant's workload. In June and July 1992, the computer printer which claimant and the other schedulers depended upon began breaking down. This diminished the schedulers' ability to complete their work efficiently, resulting in longer workdays.

In July 1992, claimant felt that he was under extreme pressure at work and he began experiencing physical symptoms, including vomiting, diarrhea, high blood pressure, muscle pains, headaches, numbness and memory loss. He sought treatment from Dr. Ushman, family physician, who diagnosed stress reaction and hypertension, prescribed medication, and took claimant off work. Claimant filed a claim.

In October 1992, claimant returned to work. His supervisor informed him that his work performance had been deteriorating since May and presented him with a written "contract" describing his work duties and insisted that claimant sign it.

Since 1991, claimant has reported both work and off-work stressors to physicians and his family.

CONCLUSIONS OF LAW AND OPINION

This is a claim for a major depression condition, allegedly resulting from workplace stress. To prevail, claimant must prove, inter alia, that employment conditions not otherwise excluded were the major contributing cause of his disease. ORS 656.802(1)(b), (2) and (3).

The Referee concluded that claimant failed to carry his burden. In reaching this result, the Referee found the opinion of Dr. Soule, treating psychiatrist, unpersuasive. In addition, the Referee considered claimant's employer's budget constraints and time limitations as conditions inherent in every work situation. Accordingly, because such conditions are not compensable causes under ORS 656.802(3)(b), the Referee upheld the employer's denial. We reach the same result, based on the following reasoning.

Claimant contends that his depression results from excessive workload, inadequate and chronically malfunctioning equipment, and unresponsive management. Assuming for the sake of argument that these factors are not generally inherent in every working situation, there is evidence supporting the existence of these workplace conditions and indicating that claimant's stress and depression resulted, in part, from them. However, there is also evidence that other, off-work, stressors contributed to claimant's depression. Thus, the question becomes whether claimant has established that compensable causes contributed more to his psychological condition than all other causes combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-311 (1983); David K Boyer, 43 Van Natta 561 (1991), aff'd mem, 111 Or App 666 (1992). Such evidence must be clear and convincing. See ORS 656.802(2)(d).

Dr. Soule, treating psychiatrist, offers the only expert evidence supporting this claim. Dr. Soule opined that the major causes of claimant's depression were work related. He stated, based on claimant's history, "There do not appear in the history to be any other events that could account for this." (Ex. 27-2). However, Dr. Soule also noted:

> "A nonwork factor that may have contributed to [claimant's] depression was that[,] as he was having more difficulty with his work environment[,] there was increased stress at home. The patient explained to me that his wife had gone through a difficult time with her employer the year previously. As [claimant] had increasing difficulties with his employer, it brought back some very painful memories and brought up some very painful emotions for her, such that there was some increased stress in their relationship as well. It is unclear to what degree this may have contributed to [claimant's] major depression." (Id., emphasis added).

Claimant's wife's son explained at hearing that his mother

> "had been through a similar ordeal with [the same employer], and I guess going -- I mean, she was real bad, and I guess going through that ordeal and then having [claimant] have to go through the same thing, problems developed in their marriage, and she got to the point where she left and went down south to stay with my brother." (Tr. 17; see Tr. 21-22, 25).

Considering Dr. Soule's impression that marital problems may have contributed to claimant's depression and the testimony suggesting that claimant's wife's history with the same employer did contribute to marital problems, we are not persuaded that Dr. Soule had a complete and accurate history concerning the extent and nature of claimant's off-work stressors.

Moreover, although Dr. Soule suspected that marital stress contributed to claimant's depression and expressed uncertainty concerning the degree of such contribution, he nonetheless stated that "[t]here do not appear . . . to be any other events [i.e., other than work-related stress] that could account for [claimant's depression]." (Ex. 27). Under these circumstances, we do not find Dr. Soule's ultimate quantitative conclusion persuasive.

In sum, we acknowledge that claimant's depression resulted in part from stress associated with his workload and insufficient mechanical and managerial support. However, in the absence of persuasive medical evidence clearly and convincingly indicating that such work-related causes contributed more to claimant's condition than all other causes combined, we conclude that the claim fails. See ORS 656.802(2).

ORDER

The Referee's order dated June 1, 1993 is affirmed.

In the Matter of the Compensation of
DENISE C. SMITH, Claimant
WCB Case No. 93-02506
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig, Gunn and Westerband.

Claimant requests review of Referee Livesley's order which upheld the insurer's denial of her neck injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant slipped and fell on snow and ice while walking from a parking lot to work. The Referee found that the employer did not exercise sufficient control over the parking area to establish the necessary work relationship to make the injury compensable. The Referee, therefore, concluded that claimant's injury did not fall within the "parking lot" exception to the "going and coming" rule.

Injuries sustained while going to or coming from work are generally not deemed to arise out of and in the course of employment (the "going and coming" rule). SAIF v. Reel, 303 Or 210 (1987). One exception is the "parking lot rule." Under this rule, injuries sustained on the employer's premises while the employee is going to or coming from work have a sufficient work-connection to be considered to have occurred "in the course of employment." However, the "parking lot" exception only satisfies the first element of the unitary work-connection analysis. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). Claimant must also establish that the injury "arose out of" employment; i.e., there must be a sufficient work-connection between claimant's employment and the injury to establish compensability. Id. at 368.

Thus, the first inquiry is whether claimant's injury occurred "in the course of employment," i.e., did the employer exercise some control over the parking lot. Employer control is manifested either by employer ownership or maintenance, or the presence of employer-created special hazards. Cope v. West American Ins. Co., 309 Or 232, 239 (1990); Sheri V. Hiltner, 42 Van Natta 1039 (1990). Claimant contends that the employer's lease of the parking lot evidences employer control.

The employer owns and maintains a parking lot adjacent to its building (hereinafter the Gardner lot). The employer had instructed claimant to park in its lot and not in another nearby lot, although there had been no objection if claimant occasionally parked in the other lot. (Tr. 6-7, 19, 41, 66). The other lot is part of a Chevron station and is located across the alley from the employer's building. The employer pays Chevron $200 a month for the use of ten parking spaces (hereinafter the Chevron lot). Chevron owns the lot. (Tr. 40, 63). There was no sign at the Chevron lot designating spaces for Gardner employees only. The employer did not have exclusive use of the Chevron lot. There was no evidence that the employer charged parking to the employees that used the Chevron lot.

There is no written lease or other written document that defines who is responsible for maintaining the Chevron lot. (Tr. 41, 65). None of the employer's employees had ever done maintenance on the Chevron lot. (Tr. 63). The employer considered it common practice that Chevron employees maintained the Chevron lot. (Tr. 40, 46, 65). No evidence was presented to establish that the employer could require Chevron to maintain the lot. Rather, the evidence suggests that the employer left maintenance of the Chevron lot to Chevron.

However, pursuant to this arrangement, the employer had the right to use the Chevron lot and that right was passed to its employees at no cost as an employment benefit. The employer made the parking spaces available for the convenience of certain employees. (Tr. 63, 67). That employer-granted right to use the lot evidences sufficient control of the area where claimant was injured to be considered part of the employer's premises. Cf. Rohrs v. SAIF, 27 Or App 505 (1976) (parking lot not part of the employer's premises where there was no evidence introduced to show that the employer had a right, either customary or legal, to use the parking lot, the parking lot was not provided as an incident of

employment and the claimant paid a separate corporation for use of the parking lot); see also Lisa D. Henderson, 45 Van Natta 559 (1993) (no employer control where under express terms of written lease, the employer was not responsible for maintenance, nor could it require the landlord to make repairs).

Having found that claimant's injury occurred on the employer's premises only establishes that the "parking lot" exception to the "coming and going" rule applies. Claimant must also establish that her injury "arose out of" her employment by showing a causal connection between her employment and the injury. Norpac Foods, Inc. v. Gilmore, supra.

The Referee found that claimant could have used the Gardner lot or could have been dropped off at the front door. Because we find that claimant used the Chevron lot solely for her husband's convenience, we agree that claimant's injury did not result from an act which was an ordinary risk of, or incidental to, her employment.

The employer neither expressly nor impliedly allowed claimant to park in the Chevron lot. Claimant had been instructed to park in the Gardner lot and claimant normally parked her car in that lot. (Tr. 7, 19). Claimant was aware that only management, sales people, warehousemen and estimators were to use the Chevron lot. Claimant, however, did occasionally park in the Chevron lot when the Gardner lot was full. (Tr. 9). Although the employer did not object if claimant occasionally used the Chevron lot, this occasional use is insufficient to show "common practice or custom" to establish employer acquiescence. See Clark v. U.S. Plywood, 288 Or 255, 267 (1980); Maurice A. Frost, 45 Van Natta 1242 (1993).

On the day of claimant's injury, her husband drove her to work because of the road conditions. (Tr. 12). He pulled into the Chevron lot because it was more convenient for him to continue onto his designation. (Tr. 17, 20-22). Claimant slipped and fell on snow/ice while walking from the Chevron lot to begin her work day. Rather than pulling into the Chevron lot, claimant's husband could have driven to one of the employer's entrances and dropped her off. (Tr. 20). Claimant did not do so, nor did she use the Gardner lot, solely because it was more convenient for her husband to use the Chevron lot. (Tr. 22, 35-36). Thus, the employer could not have contemplated that claimant's husband would drive her to work or that, if he did so, he would have used the Chevron lot rather than using another entrance to its building. But see Montgomery Ward v. Cutter, 64 Or App 759 (1983) (the employer leased a retail outlet in a shopping mall and required its employees to park in a certain part of the mall parking lot and in which it had the right to have its employees park. The claimant was injured in an area of the parking lot through which she was required by her work to travel repeatedly on a daily basis. The court held that the injury occurred "in the course of employment.").

Based on the above, we find that claimant had a purely personal motive for using the Chevron lot on the day of her injury. Consequently, claimant has failed to show a causal connection between her employment and the injury to establish compensability.

ORDER

The Referee's order dated June 21, 1993 is affirmed.

Board Chair Neidig, specially concurring.

Although I agree with the majority holding that claimant's injury did not arise out of and in the course of employment, I disagree with the majority's analysis that the employer's "unwritten lease" manifests employer control of the Chevron parking lot. Rather, I would find that the $200 monthly payment is insufficient, in itself, to establish employer control of the Chevron lot.

Other than the monthly payment to Chevron, the evidence establishes that the employer had no actual control of the area where claimant was injured. See Cope v. West American Ins. Co., 309 Or 232 (1990); Janet V. Dollens, 42 Van Natta 2004 (1990) (actual control is necessary to establish employer control). Here, the employer had no control over the conditions of the Chevron lot. See Karen Manning-Robinson, 44 Van Natta 413, 414 (1992). Because there was no written "lease," there were no express provisions regarding whether the employer or Chevron was obligated to maintain the lot or whether the employer could have required Chevron to remove the snow and ice. However, "custom or common practice" established that the employer had no responsibility whatsoever for maintaining the Chevron lot.

If, as the majority finds, that providing a parking area as a benefit and convenience to employees is enough to establish employer control, then such a conclusion will result in a disincentive to employers to provide safe parking to its employees. See William F. Gilmore, 45 Van Natta 410 (1993) (Member Gunn, specially concurring).

Thus, the evidence establishes that the employer did not own or maintain the Chevron lot. We can only speculate whether the employer could require Chevron to remove the snow and ice. I would find the $200 monthly payment too tenuous to manifest employer control. Accordingly, I would conclude that claimant's injury did not occur on the employer's premises and, therefore, the "parking lot" exception to the "going and coming" rule does not apply.

April 20, 1994 Cite as 46 Van Natta 785 (1994)

In the Matter of the Compensation of
DEBORAH WALDEN, Claimant
WCB Case No. 93-03889
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of those portions of Referee Galton's order that: (1) affirmed an Order on Reconsideration that had set aside the insurer's Notice of Closure as premature; (2) directed the insurer to pay claimant temporary disability benefits from March 27, 1993 through March 30, 1993; and (3) assessed a penalty for the insurer's allegedly unreasonable failure to pay those temporary disability benefits. On review, the issues are premature closure, temporary disability benefits, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On March 26, 1993, Dr. Richardson, claimant's attending physician, reported that claimant was medically stationary without objective findings to support an inability to return to regular work.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's conclusions and reasoning concerning the premature closure issue.

Temporary Disability Benefits

The Referee found that pursuant to ORS 656.313, the insurer was obligated to pay temporary disability benefits through March 30, 1993, the date of its second Notice of Closure. We disagree.

In its original December 14, 1992 Notice of Closure, the insurer awarded claimant temporary disability benefits through December 4, 1992. However, the March 23, 1993 Order on Reconsideration set aside the insurer's December 14, 1992 Notice of Closure on the basis that it was premature. The insurer appealed the Order on Reconsideration, but continued to process claimant's claim. It received confirmation from claimant's attending physician that claimant was medically stationary as of March 26, 1993. Thereafter, on March 30, 1993, the insurer issued a second Notice of Closure awarding claimant temporary disability benefits through March 26, 1993, the medically stationary date.

As found by the Referee, temporary disability benefits payable up to the March 23, 1993 Order on Reconsideration were properly stayed pending the insurer's appeal of that order. See ORS 656.313(1)(a). Further, benefits that accrue after the appealed order are not stayed until closure under ORS 656.268 or until the order appealed from is reversed, whichever event occurs first. ORS

656.313(1)(a)(A). Thus, under ORS 656.313(1)(a)(A), claimant would be entitled to payment of all temporary disability benefits accruing through the March 30, 1993 Notice of Closure. The issue, then, is what benefits accrued.

The insurer paid benefits through March 26, 1993. On that date, Dr. Richardson, claimant's attending physician, reported that claimant was medically stationary and that there were no objective findings that would support claimant's inability to return to regular work. We interpret Dr. Richardson's report to mean that claimant was released to regular work. Thus, claimant was no longer entitled to temporary disability benefits pursuant to ORS 656.268(3)(b) as of March 26, 1993.

As of March 26, 1993, the insurer could close claimant's claim pursuant to ORS 656.268, which it did on March 28, 1993. Since the insurer closed claimant's claim pursuant to ORS 656.268, the stay provisions of ORS 656.313(1)(a)(A) no longer applied. That is, one of the events listed in that statutory provision had occurred; i.e. claimant had been released to regular work by her attending physician. Therefore, ORS 656.313(1)(a)(A) did not require the insurer to pay temporary disability benefits past March 26, 1993, the date claimant was released to regular work.

Inasmuch as the procedural entitlement under ORS 656.313 does not operate to award claimant temporary disability from March 27, 1993 through March 30, 1993, the only other question would be whether claimant was substantively entitled to those benefits. However, under ORS 656.268(5), the Hearings Division lacks initial jurisdiction to address direct challenges to a Notice of Closure or Determination Order regarding substantive entitlement to temporary disability benefits. Ralph E. Fritz, 44 Van Natta 1168 (1992). Rather, a worker must first initiate the reconsideration process pursuant to ORS 656.268. Inasmuch as claimant did not request reconsideration of the March 30, 1993 Notice of Closure prior to requesting a hearing, the Referee was without authority to award temporary disability benefits from March 27, 1993 through March 30, 1993. Ralph E. Fritz, supra.

Since we have found that the insurer was entitled to stay payment of temporary disability benefits from March 27, 1993 through March 30, 1993, it follows that its failure to pay those benefits was not unreasonable. Accordingly, we reverse the Referee's award of a penalty.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the premature closure issue is $850, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by respondents's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 28, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which directed the insurer to pay claimant temporary disability benefits from March 27, 1993 through March 30, 1993 is reversed. That portion which awarded a 25 percent penalty for failure to pay temporary disability benefits is also reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $850, payable by the insurer.

In the Matter of the Compensation of
NEIL A. LAUFER, Claimant
WCB Case Nos. 92-04261 & 91-13295
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Snarskis, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee T. Lavere Johnson's order that awarded claimant's counsel a $10,500 attorney fee pursuant to ORS 656.386(1) for prevailing against SAIF's denial of claimant's aggravation claim for his current back condition. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are attorney fees and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Attorney Fees -- ORS 656.386(1)

After hearing, the parties submitted letters to the Referee regarding claimant's entitlement to an attorney fee under ORS 656.386(1). In his letters, claimant's counsel averred that he had spent 56 hours on the matter and relied on a referee order and order on review in Adam H. Berkey, 45 Van Natta 237 (1993) as support for his request for an enhanced attorney fee. Using a base hourly rate of $150 per hour,[1] the Referee awarded claimant's counsel an "enhanced" $10,500 attorney fee for finally prevailing at hearing regarding SAIF's denial of claimant's aggravation claim for his current low back condition. After conducting our review, we modify the Referee's attorney fee award.

On this record, we find that claimant's counsel spent 56 hours on this matter. However, we conclude that claimant's reliance on Adam H. Berkey is misplaced. In that case, a referee awarded an attorney fee of $18,500 for finally prevailing at hearing regarding SAIF's denial of the claimant's injury claim. We affirmed that award on review. Adam H. Berkey, supra. In computing that award, both the referee and this Board had the benefit of a detailed statement of services that outlined the amount of time spent and the specific services provided by claimant's counsel and his paralegal.

Here, we have the benefit of no such statement of services. Therefore, we find Adam H. Berkey to be distinguishable.

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 hearing concerning the compensability issue is $8,400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue, (as represented by the hearing record and counsels' statements regarding claimant's counsel's services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel's efforts might go uncompensated.

Penalties for Unreasonable Denial

The Referee concluded that, because this case was complex, SAIF's denial was not unreasonable at the time of issuance. Claimant argues that, even if SAIF's denial was reasonable at the time of issuance, it became unreasonable in the light of the post-denial medical evidence. We disagree.

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[1] On review, neither party contests the Referee's use of a $150 per hour rate in calculating the attorney fee award.

A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the insurer at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Continuation of a denial in the light of new medical information becomes unreasonable only if the new evidence destroys any legitimate doubt about the insurer's liability. See id. at 592.

We adopt the Referee's conclusion that, at the time of the denial, SAIF's denial was reasonable. Furthermore, we conclude that, even in light of the post-denial evidence, SAIF's denial remained reasonable. Although the majority of medical opinions support the compensability of claimant's current back condition, we are persuaded that two factors gave SAIF a legitimate reason to question its liability for the claim. First, no medical evidence refutes the April 1991 opinion of Dr. Adams, consulting orthopedic surgeon, that claimant's back complaints were partially functional. (Ex. 37). Second, Dr. Freudenberg, the surgeon who repaired claimant's 1990 knee injury, agreed with a letter drafted by SAIF's counsel, which stated that claimant did not complain of back pain to Dr. Freudenberg between August 1990 and March 1991. (Ex. 76).[2] That evidence casts at least some doubt on claimant's history of continual back pain following his July 1990 accident, which in turn casts doubt on the medical evidence that is predicated on that history. For these reasons, we conclude that, although the bulk of the post-denial medical evidence supports claimant's position, that evidence has failed to destroy any legitimate doubt about SAIF's liability for claimant's current back condition. Brown v. Argonaut Insurance Company, supra, 93 Or App at 592.

Claimant argues that SAIF intentionally misinformed Dr. Gallo about claimant's history of back pain, because Mark Goldberg, SAIF's claims examiner, had advised Dr. Gallo that claimant first sought treatment for his current back condition almost one year after his 1990 accident. (Ex. 48A). Thereafter, Dr. Gallo opined that claimant's condition was not compensable. (Ex. 49). Claimant contends that, because Dr. Gallo's opinion was predicated on a misrepresentation, SAIF's reliance on her opinion, and hence, its denial, was unreasonable. We disagree.

In light of the fact that, before Mr. Goldberg contacted her, Dr. Gallo had issued an opinion that recorded claimant's history of continual back pain following the 1990 accident, (Ex. 45-1), we question whether Dr. Gallo was misinformed, intentionally or otherwise.[3] Claimant's argument is further weakened by the fact that Mr. Goldberg advised Dr. Gallo that claimant first received treatment for his current back condition in April 1991, (see Exs. 48A, 63A), a proposition for which there is evidentiary support. However, even assuming that claimant's argument is well-taken, in this case, the most we would do is to disregard Dr. Gallo's opinions. Because we have concluded that evidence other than her opinions created a legitimate doubt about SAIF's liability for this claim, we reject claimant's argument.

Because we have concluded that SAIF's denial was reasonable, we decline to assess a penalty.

ORDER

The Referee's order dated May 3, 1993 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, we award claimant's counsel a fee of $8,400, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

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[2] On June 18, 1992, Dr. Freudenberg sent a letter to claimant's counsel, in which he stated that it was possible that claimant had complained of back pain during his post-hospitalization visits to Freudenberg's clinic. (Ex. 79). We do not consider that evidence in evaluating the reasonableness of SAIF's denial, because the record is silent regarding when SAIF became aware of the letter.

[3] Claimant began treating with Dr. Adams in April 1991, nine months after his July 1990 accident. Although it may have been more accurate for SAIF's claims examiner to advise Dr. Gallo of this delay in terms of months, we conclude that the examiner's statement that claimant waited "almost one year" before receiving treatment for his current back condition did not misrepresent claimant's course of treatment.

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case Nos. 91-11547 & 91-11151
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration of our March 24, 1994 Order on Remand that affirmed a Referee's order which increased claimant's scheduled permanent disability award from 12.75 percent for left ear hearing loss to 44.53 percent for binaural hearing loss. Objecting to several evidenciary rulings made in our order, the employer bases its request on the "lack of substantial fairness" resulting from these rulings.

In order to further consider the employer's motion, we withdraw our March 24, 1994. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case No. 92-14350
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration of our March 24, 1994 Order on Review that affirmed a Referee's order that awarded 44.53 percent (85.50 degrees) scheduled permanent disability for binaural hearing loss, whereas an October 30, 1992 Order on Reconsideration had declined to award scheduled permanent disability. Objecting to several evidenciary rulings made in our order, the employer bases its request on the "lack of substantial fairness" resulting from these rulings.

In order to further consider the employer's motion, we withdraw our March 24, 1994. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT R. MUSIC, Claimant
WCB Case No. 93-04839
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Nichols' order which upheld the SAIF Corporation's denial of his occupational disease claim for bilateral knee conditions. 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.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant, who has worked for this employer for over 25 years as a millwright and electrician, failed to establish the compensability of his occupational disease claim for degenerative joint disease in both knees and a medial meniscus tear in the right knee. We disagree with the Referee's conclusion with respect to the right knee condition.

In order to establish his occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that his work activities were the major contributing cause of his 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 Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); David K. Boyer, 43 Van Natta 561 91991), aff'd mem 111 Or App 666 (1992).

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. Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991), rev den 313 Or 210 (1992); see also Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993); John W. Walters, 45 Van Natta 55, aff'd mem 125 Or App 338 (1993). A "predisposition" is a condition of special susceptibility to a disease, not a disease in and of itself. Preston v. Wonder Bread, 96 Or App 613, rev den 308 Or 405 (1989).

Because this case involves evaluation of several potentially causal and/or predisposing factors, we find the causation issue to be medically complex. Accordingly, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Poulson, claimant's treating orthopedist, performed right knee surgery for degenerative changes in the right knee, including a medial meniscus tear. (See Exs. 3, 5, 6, 12). With respect to the cause of claimant's right knee problem, Dr. Poulson opined:

> "[Claimant] does have a traumatic arthritis of his right knee and the type of work he did [as a millwright] is certainly the type that would develop a traumatic arthritis if the person has a weakness in that area and he certainly does. As you may know, being a millwright requires climbing, crawling, stooping and kneeling very frequently. So it is my opinion again that the major contributing cause is the work he was doing over the last 25 years." (Ex. 13).

Dr. Woolpert, an orthopedist who examined claimant once at SAIF's request, observed that claimant has bowing of his knees and internal tibial torsion of his knees. He believed that these conditions, particularly in an overweight person such as claimant, produced increased weight bearing on the medial compartment of his knees, bilaterally. Dr. Woolpert then opined that "this is most likely the major contributing factor to the patient's onset of degenerative joint disease and the current status of his knees." (Ex. 8-4). He did not believe that claimant's work activities "as such" were the major contributing cause of his problem. (Id). Finally, because claimant did not describe any specific event at work that caused his symptoms to change, Dr. Woolpert believed that the meniscus tear was more likely degenerative in nature, rather than an acute tear due to specific trauma. (Id).

When medical opinion is divided, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no reasons not to do so in this case.

Dr. Poulson had an accurate medical and work history, and he had the opportunity to observe claimant's knee in surgery. We understand his opinion to be that claimant's "weakness" in his knees rendered him more susceptible to developing traumatic arthritis, given the nature of his work activities. Considering this susceptibility (which we do not factor into the "major contributing cause" analysis), Dr. Poulson nevertheless believed that claimant's work activities were the major contributing cause of his current right knee condition. Under these circumstances, we find no reason not to defer to his opinion.

In contrast, we find Dr. Woolpert's opinion less persuasive because he failed to explain whether he considered claimant's bowed knees and internal tibial torsion to be predisposing or causal factors. In addition, he failed to consider the long-term nature of claimant's work exposure (25 years) in light of his gradually developing knee problems during approximately the last 10 years.

Accordingly, relying on Dr. Poulson's opinion, we conclude that claimant has established that his work activities over the past 25 years are the major contributing cause of his current right knee condition. Therefore, we find that claimant has established a compensable occupational disease claim for his right knee condition.

However, we do not find medical evidence that supports compensability of an occupational disease claim for the left knee. Dr. Poulson's opinion is limited to the right knee. (See Ex. 13). Both Dr. Woolpert and Dr. Gooch, claimant's long-time family physician, do not believe that claimant's work activities are a significant contributing cause of his degenerative joint disease. (See Exs. 8-4, 14). Accordingly, we conclude that claimant has failed to prove the compensability of an occupational disease claim for his left knee condition.

Claimant is entitled to an assessed attorney fee for finally prevailing concerning the compensability of his right knee 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 right knee condition is $2,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 5, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the SAIF Corporation's April 7, 1993 denial with respect to the right knee is reversed. The SAIF Corporation's denial of claimant's occupational disease claim for his right knee is set aside, and the claim is remanded to SAIF for processing in accordance with law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the SAIF Corporation.

April 22, 1994 Cite as 46 Van Natta 791 (1994)

In the Matter of the Compensation of
THOMAS A. PORTER, Claimant
WCB Case No. 93-05063
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Lipton's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a cervical condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's aggravation claim failed because he failed to prove that his worsened medical condition rendered him less able to work. On review, claimant now contends that his ability to work cannot be considered in determining whether to reopen his claim for medical services.

Claimant's ability to work is not considered in a medical services claim. See ORS 656.245; Smith v. SAIF, 302 Or 396, 402 (1986); Meyers v. Darigold, 123 Or App 117 (1993). Here, however, SAIF denied a worsening, i.e., an aggravation, not compensability or medical services. (Ex. 35). Furthermore, the parties agreed at hearing that SAIF's denial was an aggravation denial. (See Tr. 4 and 5). Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Consequently, we decline to consider claimant's new theory on review.

We adopt and affirm the Referee's opinion with the exception of the sentence establishing the "last award or arrangement of compensation" as of the prior hearing. Instead, we substitute the following.

Subsequent to the Referee's order, we held in Lindon E. Lewis, 46 Van Natta 237 (1994), that evidence regarding the "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). A referee's evaluation of a worker's disability shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. ORS 656.283(7); Gary C. Fischer, 46 Van Natta 60 (1994).

Here, claimant's condition allegedly worsened after issuance of the May 9, 1991 Order on Reconsideration. Consequently, the last award or arrangement of compensation was the May 9, 1991 Order on Reconsideration. Thus, in order to establish a compensable aggravation claim, claimant must prove that his compensable cervical condition worsened since the May 9, 1991 Order on Reconsideration. Lindon E. Lewis, supra.

Although claimant's medical condition had worsened after the May 9, 1991 Order on Reconsideration, there is no evidence that claimant's worsened cervical condition has rendered him less able to work than he was at the time he was released to sedentary/light work prior to that order. Consequently, we agree with the Referee that claimant failed to prove an aggravation.

ORDER

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

April 22, 1994 Cite as 46 Van Natta 792 (1994)

In the Matter of the Compensation of
DOUGLAS L. TYREE, Claimant
WCB Case No. 93-03679
ORDER OF ABATEMENT
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant has requested reconsideration of our March 25, 1994 Order on Review that affirmed a Referee's order, which affirmed an Order on Reconsideration that awarded claimant 2 percent (3 degrees) scheduled permanent partial disability for loss of use or function of the right forearm (wrist). Specifically, claimant requests reconsideration to enable us to determine whether this case should be consolidated with a related matter, which claimant asserts demonstrates that he is entitled to additional permanent partial disability compensation.

To further consider claimant's contention, we withdraw our March 25, 1994 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ADELINE DISNEY, Claimant
WCB Case No. 93-04162
ORDER ON REVIEW (REMANDING)
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Podnar's order that affirmed a Director's Proposed and Final Order Concerning a Bona Fide Medical Services Dispute under ORS 656.327(2). On review, the issue is jurisdiction. We remand.

Claimant has a compensable right knee condition. Dr. Berselli, claimant's orthopedic surgeon, sought authorization to perform an open Trillot procedure on claimant's knee. The self-insured employer requested review of the proposed surgery by the Director pursuant to ORS 656.327. Jean Zink, R.N., on behalf of the Director, found that the proposed surgery was not appropriate and ordered that the employer 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 several objections to the order, including challenges to the Referee's findings of fact and his finding that substantial evidence supports the Director, as well as contending that it was defective because it was made upon the recommendation of a registered nurse rather than a physician. 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.

Subsequent to the Referee's order, the Court of Appeals issued Jefferson v. Sam's Cafe, 123 Or App 464 (1993), in which it found that ORS 656.327(1) expressly applies only to treatment that a claimant "is receiving" at the time review is requested. It held that the process of review by the Director 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. Id. at 467.

Here, the dispute pertains to the propriety of proposed surgery. Consequently, the employer 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. Jefferson v. Sam's Cafe, supra. Furthermore, the proceeding before the Referee consisted only of reviewing the Director's findings for substantial evidence. See ORS 656.327(2). At hearing, the Referee denied claimant's request to depose the physician assigned to the Director to review the case (Tr. 2), and denied claimant the opportunity to testify (Tr. 3). In addition, the Referee limited the evidence to that developed before the Director. (Tr. 1). 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.

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; Peter Britz, 45 Van Natta 2187 (1993). 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 Podnar 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 its 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
ROBERT L. FORTHAN, Claimant
WCB Case No. 93-04360
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Moller (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of his claim for a low back injury. On review, the issue is compensability.[1]

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

On review, claimant contends he need only establish that the "sneezing incident" was a material contributing cause of his low back condition and need for treatment. Alternatively, claimant contends that he has established that the incident was the major cause of his back condition. We disagree.

At the outset, claimant contends that the Referee erred in finding that his "sneeze" was not caused by workplace exposure. Again, we disagree. Simply stated, the evidence in this record does not establish that claimant's work activities or environment caused claimant to sneeze or that this was anything but an ideopathic sneeze.

Alternatively, even if we interpret Dr. Tilson's opinion to positively state that the workplace environment caused claimant to sneeze, we would continue to find that claimant had not established that the "sneezing" incident materially contributed to his low back symptoms and need for treatment.

Dr. Tilson, claimant's attending physician, described claimant's symptoms as a process rather than a single event. He further noted that a sneeze, in general, can be "bad news" for a person with disc disease, but was not suggesting that the January 1993 sneeze "changed [claimant's] life at all."

In conjunction with this, Drs. Fuller and Podemski opined that claimant's preexisting degenerative condition was the major cause of his ongoing back problems and need for treatment. These are the only opinions regarding the causation of claimant's current low back condition.

Drs. Fuller and Podemski clearly relate claimant's current low back condition to the noncompensable preexisting degenerative condition. Dr. Tilson, although speaking in general terms about the sneezing incident, does not relate claimant's current low back condition, either in material or major part, to the sneezing incident. Regardless of claimant's characterization of his claim, he must establish at least a material relationship between the work incident and his low back symptoms. He has not done so. Under these circumstances, we agree with the Referee that claimant has not established that his current low back condition is compensable. See ORS 656.005(7)(a).

ORDER

The Referee's order dated September 24, 1993 is affirmed.

[1] We note that claimant has requested that certain Board members recuse themselves from consideration of this case. However, because none of those Board members reviewed this case, it is not necessary to address claimant's motion.

In the Matter of the Compensation of
SUSAN M. SANCHEZ, Claimant
WCB Case No. 93-04077
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of that portion of Referee Daughtry's order that set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant apparently sustained a compensable bilateral carpal tunnel condition in July 1990, while employed as a hair stylist by Mastercuts/Regis Corporation, insured by Wausau. Claimant subsequently underwent bilateral carpal tunnel surgeries in December 1990 and April 1991. Claimant's treating physician, Dr. Nagel, performed both operations.

Although claimant's condition was improved, she did not become totally asymptomatic. She began working for the employer Shear Delight, uninsured at the time, in November 1991. Claimant's condition remained stable until after SAIF assumed coverage of the employer in March 1992. In May 1992, she reported that her symptoms began to worsen. Claimant then returned to Dr. Nagel for treatment. Recurrent right carpal tunnel syndrome was diagnosed, although no change in claimant's left carpal tunnel was evident and no treatment was recommended for the left side. Dr. Nagel performed a second carpal tunnel release on the right side in November 1992.

Claimant filed a claim against Wausau, which resulted in its December 4, 1992 denial and disclaimer of responsibility, naming Shear Delight as the responsible employer. SAIF ultimately denied and disclaimed responsibility for claimant's bilateral carpal tunnel condition. Although the settlement documents are not part of the record, claimant stipulated that the claim against Wausau was settled by disputed claim settlement and a claim disposition agreement. Claimant and SAIF were the only parties at this hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee held that the disputed claim settlement between claimant and Wausau rendered claimant's prior right carpal tunnel claim non-industrial. The Referee then framed the issue as whether claimant's current right wrist condition was compensable as a separate occupational disease claim against SAIF. The Referee concluded that the medical evidence established that the symptoms of claimant's carpal tunnel syndrome constituted the disease and that claimant's employment for Shear Delight worsened the symptoms, requiring claimant to seek medical treatment. Accordingly, the Referee held that claimant's current right carpal tunnel syndrome was compensable as a separate occupational disease claim for which SAIF was liable.

Given the repetitive nature of claimant's work activities, we analyze her occupational disease claim under ORS 656.802(1)(c). Claimant must prove that work activities were the major contributing cause of her right carpal tunnel syndrome. See ORS 656.802(2). A worsening of symptoms alone is insufficient unless the medical evidence establishes that the manifested symptoms are the disease. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

The Referee found that the symptoms of claimant's right carpal tunnel syndrome were the disease. The Referee then concluded that claimant's work activities caused claimant's symptoms to worsen, thus requiring medical treatment. According to the Referee, this was sufficient to establish a compensable occupational disease claim. We disagree.

Warren and Vorderstrasse are distinguishable. In Warren, the court found that the carpal tunnel syndrome for which the claimant was seeking compensation was a complex of symptoms and that there was no distinction drawn between the syndrome and any underlying carpal tunnel disease. Accordingly, the court concluded that the symptoms were the disease. 103 Or App at 278. In Vorderstrasse, the court found that the Reynaud's Phenomenon for which the claimant was seeking compensation was made manifest only by the symptoms giving rise to the claim. Again, the court concluded that the symptoms were the disease. 104 Or App at 501-502.

Here, in his deposition, claimant's treating physician, Dr. Nagel, clearly drew a distinction between claimant's symptomatology, which, according to Dr. Nagel, was worsened by claimant's work activity at Shear Delight, and the underlying scar tissue from claimant's prior right carpal tunnel release, which, according to Dr. Nagel, was the "major contributing cause" of claimant's need for a second right carpal tunnel release. (Ex. 41-8). Dr. Nagel emphasized that the symptoms of carpal tunnel can wax and wane without a change in the underlying condition. (Ex. 41-16). Such a description further reinforces the distinction drawn between the carpal tunnel symptomatology and the underlying condition.

The Referee found, and claimant contends, however, that the symptoms of carpal tunnel syndrome and the disease are one and the same. Claimant relies on Dr. Nagel's testimony that a doctor would not treat carpal tunnel in the absence of symptoms, even with abnormal electrodiagnostic studies. (Ex. 41-15). Claimant also cites Dr. Nagel's apparent agreement that the scar tissue from the prior surgery was merely a "passive contributor" to claimant's carpal tunnel syndrome. (Ex. 41-14). We reject claimant's contentions.

Dr. Nagel never testified that the symptoms of carpal tunnel syndrome are the disease. Also, Dr. Nagel never explained what was meant by a "passive contributor." We are very reluctant to accord much significance to this testimony where claimant's counsel used this terminology and Dr. Nagel never explained its meaning. In any event, Dr. Nagel clearly and unambiguously testified that the scar tissue from the first noncompensable surgery was the major contributing cause of claimant's current need for medical treatment.

Given this, and the clear distinction Dr. Nagel drew between the underlying scar tissue from the first carpal tunnel surgery, for which SAIF was not responsible, and claimant's symptoms, we cannot conclude based on this record that the medical evidence establishes that the symptoms of carpal tunnel syndrome and the underlying disease are the same. Accordingly, we do not find that claimant's symptoms are the disease for purposes of establishing compensability.

Claimant must therefore prove that work activities are the major contributing cause of her right carpal tunnel syndrome or its pathological worsening. Because this issue presents a complex medical question, its resolution turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publisher's Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

As previously mentioned, Dr. Nagel clearly opined that claimant's prior noncompensable right carpal tunnel condition and related surgery were the major contributing cause of claimant's current condition and second carpal tunnel release. As treating physician, we give greater weight to his opinion absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). We find none in this case.

As Dr. Nagel explained, he has had the advantage of following claimant's condition since 1990, he performed claimant's surgeries and he has been actively involved in the evaluation of her condition. (Ex. 41-7). For these reasons, we have no persuasive reason not to defer to his opinion. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Moreover, his opinion is supported by other doctors involved in this claim.

Dr. Radecki, an examining physician, agreed that claimant's most recent right wrist surgery was the result of scar tissue from the first carpal tunnel release. (Ex. 40-3). Dr. Radecki further commented that there was no evidence that claimant's employment for Shear Delight pathologically worsened her underlying carpal tunnel condition. (Ex. 40-3). Dr. Baker, another examining physician, opined that

claimant's preexisting noncompensable right carpal tunnel condition remained the major contributing cause of claimant's need for treatment for her right carpal tunnel condition as of June 1992. (Ex. 23-4). Although another examining physician, Dr. Jewell, attributed claimant's current right carpal tunnel condition to her employment at Shear Delight, his opinion, based on a one-time examination, does not overcome the weight accorded to Dr. Nagel, claimant's treating doctor. This is especially true where substantial medical evidence buttresses Dr. Nagel's opinion, as noted above.

Based on our review of the record, particularly the medical evidence, we are not persuaded by a preponderance of the evidence that claimant's underlying right wrist condition has worsened and, even if it has, that the major contributing cause of that worsening is claimant's post-March 1992 work activities. We recognize, as did the court in Warren and Vorderstrasse, that frequently in carpal tunnel syndrome claims, the symptoms are deemed to be the disease. However, since the medical evidence in this case establishes that the symptoms are the result of non-compensable scar tissue, we are unable to conclude that the symptoms are the disease, or that the work activities are the major contributing cause of the symptoms. Accordingly, we conclude that her claim is not compensable.

ORDER

The Referee's order dated June 24, 1993 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

April 25, 1994 Cite as 46 Van Natta 797 (1994)

In the Matter of the Compensation of
JOSEPH M. GRABOWSKI, Claimant
WCB Case Nos. 93-03372, 93-02158, 93-02503, 93-01122, 92-16009 & 93-01968
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Wallace & Klor, Defense Attorneys
Stoel, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

AIAC requests review of Referee Neal's order that: (1) set aside its denial of claimant's bilateral arm condition; and (2) upheld denials of the same condition issued by Crawford & Co., the SAIF Corporation, the Hartford Insurance Co., and Farmers Insurance Group. In its reply brief, AIAC also moves to strike a portion of claimant's respondent's brief. On review, the issues are compensability and, if compensable, responsibility. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

While working in Arizona in 1987, claimant developed pain, numbness and cramping in his hands. In November 1987, claimant moved to Oregon, working at Hyland Hills Care Center.

In May 1988, claimant sought treatment for his hands from Dr. Layman, hand surgeon, who diagnosed carpal tunnel syndrome. In June 1988, Dr. Layman performed right carpal tunnel surgery and, in July 1988, left carpal tunnel surgery. In September 1988, claimant developed a ganglion in his right wrist which was surgically excised by Dr. Layman. Hyland Hills accepted claims for bilateral carpal tunnel syndrome and a ganglion of the right wrist.

In November 1988, claimant was terminated from Hyland Hills. Beginning in March 1989, claimant worked for a period of time at the Hamilton Hotel as a maintenance man. In December 1989, while working for Pro Staff, Inc., claimant developed a second ganglion in his right wrist which Dr. Layman again surgically removed. After litigation, the SAIF Corporation, on behalf of Pro Staff, was found responsible for the ganglion.

Claimant worked at Camelot Care Center from March 1990 through November 1990. In August 1990, claimant developed a third ganglion, which Dr. Layman surgically excised. AIAC, on behalf of Camelot, accepted the ganglion. Claimant next worked as a clerk for Pets of Joy. From November 1992 through the May 1993 hearing, claimant worked at The Old Barn as a cook.

On September 8, 1992, claimant sought treatment from Dr. Long, physical medicine specialist, for bilateral hand cramping and elbow pain. In December 1992, claimant was examined by Dr. Layman. Both Dr. Long and Dr. Layman diagnosed ulnar nerve compression at the elbows. Dr. Layman recommended surgery.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

In his respondent's brief, claimant challenged the persuasiveness of the opinion of Dr. Radecki, who examined claimant and found that his bilateral arm condition was not caused or worsened by work exposure. As support, claimant submitted a portion of a deposition transcript of Dr. Radecki's testimony regarding another claimant in a separate proceeding. AIAC moves to "strike" the deposition transcript from claimant's brief, arguing that the material was not included in the record at hearing and is not relevant to this proceeding.

We first note that, except for untimely submitted briefs, there is no statutory or administrative provision for not considering, or striking, briefs submitted on review. See OAR 438-11-020. Instead, when a party submits material on review that was not admitted at hearing, we do not substantively consider the documents but treat such a submission as a request for remand. See e.g. Judy A. Britton, 37 Van Natta 1262 (1985). Therefore, we consider claimant's inclusion of the deposition transcript as a motion for remand to the Referee for admission of additional evidence and AIAC's motion to strike as an objection 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. ORS 656.295(5). In order to satisfy this standard, a compelling reason must be demonstrated, including a showing that the evidence concerns the claimant's disability. See Compton v. Wyerhaeuser Co., 301 Or 641, 646 (1986).

We find that, because Dr. Radecki's testimony was elicited in a different proceeding from this case and concerned another claimant, the deposition transcript is entirely irrelevant to claimant's disability. Therefore, claimant has failed to show a compelling reason to remand and we deny the motion.

Compensability

We agree with the Referee that claimant proved compensability. (Exs. 72, 78, 88, 91, 94). See ORS 656.802(2). The only contrary evidence was from Dr. Radecki, who stated only that it was "possible that [claimant] has a subtle diffuse peripheral neuropathy of unknown etiology, possibly related to alcohol or other exposures in the past that could * * * contribute to ulnar nerve damage[.]" (Ex. 73-5). However, inasmuch as his opinion was stated in terms of possibility, rather than probability, we find that it does not overcome the remaining opinions. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Responsibility

We first note that, according to AIAC, the last injurious exposure rule governs the determination of responsibility. We agree with the Referee that the rule is not applicable since claimant established the actual cause of his arm condition. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984); Bracke v. Baza'r, 293 Or 239, 247-48 (1982); Eva R. Billings, 45 Van Natta 2142 (1993).

When Dr. Layman examined claimant in December 1992, he reported that, based on his history, claimant's condition "became more symptomatic while working at the Camelot Care Center, but is continuing to progress at this time." (Ex. 70-2). Dr. Layman subsequently indicated that, when he first examined claimant on May 3, 1988, claimant exhibited symptoms that were consistent with an ulnar nerve compression. (Ex. 78-1). Dr. Layman further stated that "all the work activity [claimant] has done in the interim between 5/3/88 and the present time could have significantly contributed to his ulnar nerve compression and need for treatment in that they were activities requiring repetitive elbow flexion and certainly would exacerbate a low grade ulnar compression[.]" (Id. at 1-2).

In a subsequent opinion, Dr. Layman reiterated that claimant's initial symptoms were consistent with ulnar nerve compression. (Ex. 91). However, Dr. Layman further indicated that, during his treatment of claimant in 1990, when claimant worked at Camelot Care Center, "he made no reference to symptoms that would be consistent with ulnar nerve compression at the elbow." (Id.) Dr. Layman concluded that, "[b]*ased on an absence of history by myself in 1990, * * * I would be inclined not to relate his current condition * * * to his work at Camelot Care Center, but rather to work that he has done since that time, and work activity which precipitated the symptoms that resulted in his requesting treatment for the condition in September of 1992." (Id.)

Dr. Layman's final chartnote, however, stated that, although claimant may have had some ulnar nerve compression in 1988, "he was asymptomatic" at that time "and in the interim he may have cleared, but he has now become symptomatic and I would relate the major contributing cause of his need for treatment * * *, by history, [to] his activity that he was performing while at work at Camelot Care Center." (Ex. 94).

Dr. Long, based on the history he obtained from claimant, reported that claimant's "ulnar problems were well established and clinically significant in mid 1988 when he saw Dr. Layman." (Ex. 72). He further stated that, because he was not aware of "any convincing evidence that his ulnar lesions worsened" between 1988 and 1992, claimant's condition was caused by the same 1988 work conditions that resulted in the carpal tunnel syndrome. (Exs. 72, 88).

In evaluating the medical opinions, we find that Dr. Layman's opinion is inconsistent. Dr. Layman first indicated that claimant initially exhibited symptoms that were consistent with an ulnar nerve compression at the elbow and attributed the condition to all of claimant's employment after 1988. A subsequent opinion, however, indicated that claimant complained of no ulnar nerve compression symptoms in 1990 and related the condition to work performed after 1990. Dr. Layman's final opinion found that claimant was asymptomatic in 1988 and attributed his condition in major part to work at Camelot Care Center.

We find that the inconsistency of Dr. Layman's opinion provides a persuasive reason for not deferring to it. See Weiland v. SAIF, supra. Therefore, we rely on the remaining opinion by Dr. Long demonstrating that claimant's work in 1988 with Hyland Hills Care Center caused his ulnar nerve compression. Furthermore, Dr. Long's opinion is supported by Dr. Radecki's opinion that, based on a comparison of nerve conduction tests taken in 1988 and 1992, claimant's condition did not worsen after 1988. (Ex. 93).

Therefore, based on Dr. Long's opinion, we conclude that Hyland Hills Care Center is responsible for claimant's ulnar nerve compression.

Alternatively, even if the last injurious exposure rule were applicable, we would come to the same result. As discussed above, we found that the medical evidence showed that claimant's condition was caused by his work at Hyland Hills Care Center. Therefore, whichever subsequent employer would be assigned liability based on the last injurious exposure rule, we would conclude that such employer could establish that work conditions with Hyland Hills Care Center were the sole cause of the ulnar nerve compression. Thus, that employer could shift responsibility to Hyland Hills Care Center because work exposure with the employer did not affect claimant's condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984).

Finally, inasmuch as we have found Crawford/Hyland Hills responsible based on the merits, we need not address AIAC's contention that Crawford/Hyland Hills is responsible because of its alleged failure to comply with the notice requirements of ORS 656.308(2).

Finally, since Crawford/Hyland Hills is responsible for the claim, it is likewise responsible for the Referee's $2,800 attorney fee award.

Claimant's attorney is also entitled to an assessed attorney fee for services on review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $1,200, to be paid by Crawford/Hyland Hills, the carrier responsible for this claim. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 24, 1993 is affirmed in part and reversed in part. That portion of the order finding AIAC responsible is reversed. AIAC's denial of responsibility for claimant's ulnar nerve condition is reinstated and upheld. Crawford/Hyland Hills Care Center's denial is set aside. The claim is remanded to Crawford/Hyland Hills Care Center for processing according to law. Crawford/Hyland Hills is responsible for the Referee's $2,800 attorney fee award. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by Crawford/Hyland Hills.

In the Matter of the Compensation of
MARILYN K. McMASTERS, Claimant
WCB Case Nos. 92-09365 & 92-05850
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Roberts, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Nielsen's order that: (1) found that claimant's aggravation claim for her current thoracic and bilateral shoulder injury claim against Cigna Insurance Companies was untimely; and (2) upheld the self-insured employer's denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Facts."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant had not filed her aggravation claim against the insurer (Cigna) within 60 days from the self-insured employer's disclaimer of responsibility, claimant was precluded from establishing a compensable aggravation claim with Cigna, pursuant to ORS 656.308(2). We disagree.

Subsequent to the Referee's order, we issued our decision in Jon F. Wilson, 45 Van Natta 2362 (1993). In Wilson, we held that 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. See Byron E. Bayer, 44 Van Natta 1686, 1687 (1992). However, we further concluded that the claimant's failure to file a claim against a carrier within 60 days of the second carrier's responsibility disclaimer did not preclude the claimant from asserting compensability against the first carrier. We concluded that ORS 656.308(2) addresses responsibility for a claim and does not pertain to compensability. Therefore, we held that the claimant in Wilson was not precluded from filing an occupational disease claim against the first carrier, provided that the claimant timely complied with the requirements set forth in ORS 656.807(1) for the filing of such a claim. Wilson, supra.

Although the present case does not involve an issue of an improper disclaimer by an insurer, we nonetheless extend the rationale expressed in Wilson to this case. As explained in Wilson, because ORS 656.308(2) pertains to responsibility, rather than compensability, we find no reason to preclude claimant from attempting to establish an aggravation claim with Cigna. Accordingly, we conclude that claimant's failure to comply with the 60 day time limit of the responsibility disclaimer statute does not bar claimant from proving compensability of her claim.

Here, there is no contention, and we find no evidence, that claimant's aggravation claim pursuant to ORS 656.273 was untimely. Consequently, we turn to the merits of claimant's aggravation claim for her worsened back and shoulder condition.

Claimant is entitled to additional compensation for a worsened condition resulting from the original injury. ORS 656.273(1). To establish an aggravation claim for an unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Furthermore, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Claimant's compensable 1989 injury involved her right shoulder and was diagnosed as right parascapular musculoskeletal strain. Claimant also had lower back pain, diagnosed as a lumbosacral strain. Claimant's claim was last closed by a January 8, 1990 Notice of Closure which awarded temporary disability only. At the time of the 1990 Notice of Closure, claimant was released to regular work without limitations. Although her then treating doctor, Dr. Levy, noted that claimant had chronic back pain and he recommended a job change to less physical work, claimant was able to return to her regular work as a motel maid.

Following the February 19, 1992 incident at work, claimant was treated in an emergency room for bilateral shoulder pain, diagnosed as acute thoracic muscle strain and spasm. Claimant was subsequently taken off work by her treating physician, Dr. Marie. Claimant testified that, following the February 1992 incident, although her right side was painful and she experienced increased symptoms, that area remained basically the same. However, claimant also testified that her left side was painful, which was different from the previous problems she had experienced. Following the February 1992 incident, claimant was never released to her regular work as a motel maid and she did not return to her job.

Dr. Woolpert, who examined claimant on behalf of the employer, opined that claimant's current complaints were related to the August 1989 injury. Dr. Woolpert described claimant's current condition as a symptomatic exacerbation of a chronic preexisting condition. Furthermore, although Dr. Woolpert questioned the accuracy of claimant's range of motion findings, he found that claimant had some moderate range of motion limitations with respect to her dorsal and cervical spine. Dr. Marie, claimant's treating doctor, concurred with the opinion of Dr. Woolpert.

Under the circumstances, we find that claimant has shown a worsening of her condition by medical evidence supported by objective findings. Moreover, although claimant missed some work as a result of her original injury, she was able to return to her regular work as a motel maid. Following the February 1992 incident, however, claimant was not able to return to work. Consequently, claimant has established a diminished earning capacity. Finally, because claimant did not receive a prior permanent disability award, she need not establish that the worsening was in excess of the disability for which she was previously compensated. See ORS 656.273(8); Louis A. Duchene, 41 Van Natta 2399 (1989). Therefore, we conclude that claimant's disabling condition is a compensable aggravation of her industrial injury with Cigna.

Finally, turning to the issue of responsibility, we conclude that the medical evidence fails to establish that claimant sustained a new injury with the employer. Dr. Woolpert, who examined claimant on behalf of the employer, reported that claimant had continued to experience similar back and shoulder pain following her initial injury. Dr. Woolpert opined that he believed claimant's August 1989 injury was the cause of her "current problems," and the February 1992 incident was a merely a symptomatic exacerbation of a chronic preexisting condition. Dr. Marie, claimant's treating physician, agreed with Dr. Woolpert's report.

The reports of Drs. Woolpert and Marie are the only medical reports which discuss whether claimant sustained a new injury in 1992. We find those opinions to be persuasive and consistent with claimant's testimony. Accordingly, we conclude that the evidence does not support a finding of a "new injury" in February 1992. Therefore, Cigna cannot shift responsibility to the employer pursuant to ORS 656.308.

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 issue of aggravation is $3,000, to be paid by Cigna. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated June 18, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which found that claimant's claim against Cigna Insurance Companies was untimely is reversed. Cigna's denial of claimant's aggravation claim is set aside and the claim is remanded to Cigna for processing according to law. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by Cigna. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOHN D. RHOADES, JR., Claimant
WCB Case No. 92-15483
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Referee Barber's order that: (1) upheld the SAIF Corporation's denial of his right leg injury claim on the basis that he was not entitled to Oregon Workers' Compensation benefits for an injury that occurred in the State of Washington; and (2) offset any temporary disability benefits paid under a Washington claim against an interim compensation award. In his brief, claimant contends that a penalty should be assessed for SAIF's alleged failure to timely pay interim compensation. SAIF cross-requests review of those portions of the order that: (1) awarded claimant interim compensation; and (2) awarded a penalty and associated attorney fee for failure to provide discovery. On review, the issues are subjectivity, interim compensation, offset, penalties and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

Claimant, an Oregon resident, was an employee of a Hermiston, Oregon, employer at the time of injury. The employer placed its employees in temporary jobs with various clients in both Oregon and Washington. The employer set its employees' wages. (Ex. 8B-2). The employees submitted time cards to the employer. (Ex. CC). The employer paid its employees with checks drawn on an Oregon bank. (Ex. AA-10). The employer made the checks available in the Oregon office each week. (Ex. AA-10). The employer withheld claimant's taxes from his paychecks. It withheld state taxes for the wages claimant earned while working in Oregon and none for the wages claimant earned while working in Washington, which has no state income tax. (Ex. 10).

The employer advised its employees of the location of the job; the duration, if known; and the rate of pay. Employees were not required to accept any particular job in any particular location. When one job ended, employees were to let the employer know that he or she was available for another temporary assignment.

The employer hired claimant in Oregon. As part of the hiring process, claimant signed a Waiver and Release which states: "[Claimant] . . . executes this agreement in consideration of being employed by the employer . . . and with the knowledge and understanding that [claimant] is an employee of [the employer], and as such will be protected by the Workmen's Compensation Law of the State of Oregon, and will be covered by Workmen's Compensation insurance procured and kept in force by [the employer]." In this document, claimant agreed to release the employer's client from all liability for an injury to claimant's person or property while claimant was working as a temporary employee on the client's premises. (Ex. AA-3).

At the time of hire, the employer informed claimant that, in the case of a severe injury, he was required to report it to the employer and come into the employer's premises to fill out a workers' compensation form before getting medical care. (Ex. AA-5 and AA-8).

Claimant was required to get permission from the employer to become a client's permanent employee, which could only be done after he had been on the employer's payroll for eight weeks while working for that client. (Ex. AA-8). Claimant was not the employee of the employer's client.

Claimant's first temporary assignment was with an Oregon client. After he was laid off, the employer sent him to interview for a temporary position with another Oregon client. Claimant did not go to work for that client. On July 20, 1992, the employer assigned claimant to a temporary job with a client located in the State of Washington.

On October 5, 1992, claimant injured his leg on the job. He continued to work, but on October 11, 1992, the pain increased to the point that he could work no longer. He went to an emergency room where he was diagnosed with a fractured right leg. The same day, he notified the employer of his injury and diagnosis. (Ex. EE-1).

The employer filed a workers' compensation claim in Washington on claimant's behalf. (Ex. 1). On November 20, 1992, claimant filed a claim with SAIF (the employer's insurer), requesting prompt payment of interim compensation. (Ex. 2C-1). SAIF issued a denial on November 23, 1992. (Ex. 5). On December 4, 1992, the State of Washington accepted claimant's claim and paid time loss. (Ex. 8).

On November 25, 1992, claimant was released to regular work. (Exs. EE-1 and 7). He did not return to work in Washington. On January 12, 1993, the employer assigned claimant to a temporary job with an Oregon client. (Exs. EE-2 and 8B).

On January 25, 1993, claimant requested discovery of "any kind of written contract document, memoranda, agreement, or any document reflecting in writing the parties' oral agreement regarding the relationship of [the employer] in Hermiston and the winery where [claimant] was injured." (Ex. 9). The hearing was convened on February 25, 1993. Documents were received on the day of hearing. (Tr. 6 and 9).

CONCLUSIONS OF LAW AND OPINION

Subjectivity

Claimant contends that he was an Oregon subject worker at the time he sustained the otherwise compensable injury. We agree.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or 186 (1992). Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. We have previously held that in order for the out-of-state work to be "incidental" to work performed in Oregon for an Oregon employer under ORS 656.126(1), there must be proof of an established employment relationship between the worker and his Oregon employer before the out-of-state injury occurs. Adam H. Berkey, 45 Van Natta 237 (1993); Steven A. Dancer, 40 Van Natta 1750 (1988); Daryl W. Hugulet, 37 Van Natta 1518 (1985). Proof of such a relationship is established if the worker has a reasonable expectation of returning to work for the employer in Oregon. Roy L. Center, 44 Van Natta 365 (1992); Lyle E. Estes, 43 Van Natta 62 (1991).

However, in applying the test, no one factor controls. Rather, all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations that the employer otherwise is subject to and the residence of the employees. Northwest Greentree, Inc. v. Cervantes-Ochoa, supra, (citing Power Master, Inc. v. Blanchard, 103 Or App 467, 471 (1990)); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, 635 rev den 303 Or 590 (1987). Furthermore, when, as here, employees are transient and work in various locations in more than one state, it is necessary to look at more than simply the sequence of assignments. Power Master, Inc. v. National Council on Comp. Ins., 109 Or App 296, 299 (1991).

The preponderance of the evidence indicates that claimant's work outside Oregon was temporary. Claimant was not hired with an understanding that he would work in any particular location. Moreover, there is no evidence that claimant attempted to change his status with the Washington client to become the client's permanent employee. Furthermore, unlike the claimant in Daryl W. Hugulet, supra, claimant had an employment relationship with the employer in Oregon before the out-of-state injury occurred and he had a reasonable expectation of returning to work for the employer in Oregon; in fact, he did return to work for the employer in Oregon.

In its brief, SAIF suggests that because claimant was to be assigned to various clients of the employer, there was no Oregon connection. We conclude that SAIF's focus is misplaced. It is not the location of the "client" to which claimant is assigned (and with which claimant has no employment relationship) that controls, but rather the relationship of claimant with his Oregon employer. The fact that claimant may be temporarily assigned anywhere across the country does not change the fact that his ongoing employment relationship is with the Oregon employer. Although his assignments may have placed him temporarily out of state, his contractual employment relationship with the employer was expected to be ongoing here in Oregon.

Other relevant circumstances indicate that, although the employer's accounting functions took place at its Idaho headquarters, the employer hired its employees in Oregon, the Oregon manager supervised the employees, and the employer paid its employees in Oregon with checks drawn on an Oregon bank.

We conclude that these circumstances weigh in favor of finding that claimant had an established employment relationship between the worker and his Oregon employer prior to the occurrence of the out-of-state injury. Furthermore, the intent of the employer and the understanding of the employee are unclear at best. The employer required claimant to sign a Waiver and Release as a condition of his employment that indicated to claimant that he would be covered by Oregon Workers' Compensation Law. At the same time, the employer understood that its workers would be subject to Oregon workers' compensation and tax law while working in Oregon and Washington workers' compensation and tax law while working in Washington. However, there is no indication that claimant had a clear understanding prior to his injury that his claim would be submitted by the employer as a Washington claim rather than an Oregon claim simply because his injury took place in Washington.

Consequently, we conclude, based on the preponderance of the evidence, that claimant was an Oregon subject worker at the time he sustained the compensable injury to his right leg.

Interim Compensation

SAIF contends that no interim compensation was due because claimant's claim was void. Because we have concluded that claimant was a subject worker at the time of his injury, he is entitled to interim compensation. Bell v. Hartman, 289 Or 447 (1980) (interim compensation is due the fourteenth day after notice or knowledge unless the claim is denied or the claimant is not a subject worker). Consequently, we adopt and affirm the Referee's opinion on the interim compensation issue.

Offset

An offset is allowed for temporary disability benefits received in excess of the statutory amount provided by ORS 656.210(1). See Petshow v. Ptld. Bottling Co., 62 Or App 614, 619 (1983), rev den 296 Or 350 (1984). When a worker has a claim under a federal workers' compensation statute or the workers' compensation law of another state, territory, province, or foreign nation for the same injury or occupational disease as the claim filed in Oregon, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under Oregon workers' compensation law, upon approval by the Director. OAR 436-60-020(9); Gonzalo M. Cervantes, 44 Van Natta 1840 (1992).

Although the rule specifically permits an offset of the total amount of compensation paid under a foreign jurisdiction upon approval by the Director, the Board and its Hearings Division have the authority to address an offset request and may also authorize recovery of overpayments. We reason as follows.

The Board and the Hearings Division have jurisdiction over matters concerning a claim, that is, matters in which a worker's right to receive compensation, or the amount thereof, is directly in issue. ORS 656.283(1); 656.704(3) and 656.708. An offset is a matter concerning a claim. See generally, SAIF v. Zorich, 94 Or App 661 (1989); Steven F. Sutphin, 44 Van Natta 2126 (1992), Steve E. Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 511 (1992). Consequently, the Board has inherent authority to authorize an offset.

Inasmuch as the Board has authority to authorize an offset, we look to the formula as set forth in OAR 436-60-020(9) as a basis for granting an offset. The worker is entitled to the full amount of compensation due under Oregon law. OAR 436-60-020(9). The total amount of compensation paid or awarded under the law of the other state shall be credited against the compensation due. Id.

Here, since the claim is compensable, temporary disability is due until terminated pursuant to ORS 656.268. Consequently, the offset should be extended beyond the interim compensation period designated by the Referee. Therefore, if claimant was also receiving temporary disability payments on the Washington claim, the offset should extend throughout that period until the claim is closed by SAIF according to law.

Penalty for SAIF's Failure to Timely Pay Interim Compensation

In his brief, claimant requests that we assess a penalty for SAIF's failure to timely pay interim compensation. This issue was not raised at hearing. Generally, we do not consider for the first time on review an issue that was not raised at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). We decline to do so here.

Penalty and Attorney Fee for Unreasonable Discovery

We adopt and affirm the Referee's opinion on this issue.

Assessed Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's denial and for successfully defending against SAIF's cross-request for review on the interim compensation issue. ORS 656.386(1); 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 at hearing and on review concerning the denial and interim compensation issues is $3,500, 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 appellate briefs, claimant's counsel's statement of services, and the hearing record), the complexity of the issues, and the value of the interest involved.

Inasmuch as a penalty and attorney fee are not considered compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for services on review defending the Referee's penalty and attorney fee assessments. State of Oregon v. Hendershott, 108 Or App 584 (1991); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated April 30, 1993 is reversed in part, modified in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. SAIF is authorized to offset temporary disability paid under the Washington claim against temporary disability due under the Oregon claim provided that claimant receives the full amount of compensation due him under Oregon 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 SAIF Corporation.

In the Matter of the Compensation of
WILLIAM J. THAYER, Claimant
WCB Case Nos. 92-14126, 92-09836 & 92-06969
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Tom Dzieman (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The noncomplying employer requests review of Referee Brown's order that set aside the SAIF Corporation's denial, on its behalf, of claimant's claim for a left finger injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

On September 15, 1990, while painting a house for the employer, claimant accidentally injected paint thinner into his left index finger while cleaning out an airless sprayer.

After the injury, claimant's wife took him to Mr. Warren's house to call the poison control center and then took claimant to a hospital emergency room for treatment. While claimant remained at the hospital, claimant's wife and Mr. Warren returned to the house and removed the airless sprayer.

As a result of the injury, claimant's left finger was amputated on September 19, 1990. (Exs. 8, 10).

The employer, Oregon Pacific Builders, is a partnership consisting of four partners. The specifications for painting the house, which was located on Laura Court in Medford, originally called for latex paint. However, Mr. Chandler, one of the four partners of Oregon Pacific Builders, decided that an oil based primer would be used.

After an investigation, the Department issued an order finding the employer noncomplying. (Ex. 16). The employer requested a hearing on the order. On October 7, 1992, SAIF, on behalf of the employer, denied the claim. (Ex. 21). On February 1, 1993, without withdrawing its objection to claimant's claim, the employer withdrew its hearing request regarding the Department's order finding it to be a noncomplying employer. (Ex. 22).

At the hearing, the Referee found claimant to be a credible witness.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was within the course and scope of his employment for the employer when he accidentally injected his left index finger with paint thinner while cleaning an airless sprayer. We agree, and adopt the Referee's conclusions and reasoning with the following supplementation.

On review, the employer contends that under the factors contained in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985), claimant was not in the course and scope of employment when he was injured. We disagree.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach which poses the following question: "Is the relationship between the injury and the employment sufficient that the injury should be compensable?" Id. at 642. Seven factors have been identified to determine 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 employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Grisvold, supra. All of the factors may be considered; no one factor is dispositive. Id.

Applying the Mellis factors to this case, we conclude that claimant was in the course and scope of his employment when the injury occurred. Specifically, we find that the employer contracted with claimant to paint the house it was constructing on Laura Court. Therefore, painting of the house was for the benefit of the employer. We note that the Referee found that the employer, through one of its partners, Mr. Chandler, directed claimant to use an oil based primer on the Laura Court house. Therefore, the activity claimant was engaged in, painting the house and cleaning the paint sprayer with paint thinner, was contemplated by the employer. In addition, claimant was directed to paint the house by the employer and was not on a personal mission at the time of his injury. The use of paint thinner to clean the airless sprayer was an ordinary risk of, and incidental to, painting the house. Finally, claimant was paid by the employer for the activity and was on property owned by the employer. Considering these factors, we conclude that claimant was within the course and scope of his employment when his injury occurred.

On review, the employer also contends that claimant is not credible based upon inconsistencies in the record. We disagree.

First, the employer asserts that claimant is not credible because he continued to charge supplies on the employer's account after the injury. At hearing, claimant acknowledged that some of the bills for supplies "could have been" for his personal account. The employer did not establish that claimant intentionally charged personal supplies to its account. However, even assuming that claimant intentionally charged items to the employer's account, this fact by itself does not establish that claimant did not sustain the left finger injury in the course and scope of his employment.

The employer also argues that claimant's testimony is inconsistent with the record because the report of the Department's field investigator indicated that claimant was off work for 16 weeks, whereas the employer's payroll records indicate that claimant was off work two weeks as a result of the injury. Claimant asserts that it is likely that he or the investigator made an error and that instead of 16 "weeks" the investigator's report should have stated that claimant was off work for 16 "days." We are not convinced that this discrepancy is an intentional fabrication rather than a simple error. The employer also argues that some documents, the 801 and the field investigator's report, indicate that the date of injury was September 14, 1990 rather than September 15, 1990. However, the hospital emergency room report supports claimant's assertion that he was injured on September 15, 1990 about 30 to 40 minutes before arriving at the hospital. (Ex. 4).

Finally, we reject the employer's assertion that claimant's testimony is inconsistent with that of his wife. Claimant testified that his wife had helped him on painting jobs in the past. Claimant's wife testified that she had not worked at the Laura Court house with claimant before the day he was injured. (Tr. 37). Claimant's wife did not testify that she had never worked with claimant at all before the date of injury. Thus, this testimony is not inconsistent.

After reviewing the record, we find no material inconsistencies between claimant's testimony and the record. Therefore, we agree with the Referee that claimant is a credible witness and has established that his injury occurred in the course and scope of employment.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by SAIF on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the 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 16, 1993 is affirmed. For services on review, claimant's attorney is awarded $1,000 payable by SAIF, on behalf of the noncomplying employer.

In the Matter of the Compensation of
BERNARDO D. CALCAGNO, Claimant
WCB Case Nos. 92-16445, 92-15244 & 92-11158
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Myzak's order which declined to assess a penalty for the insurer's allegedly unreasonable denial of claimant's right foot condition. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

Claimant, a machinist, sought treatment for right ankle pain on December 10, 1990, for a condition diagnosed as right achilles tendonitis. The insurer initially denied "ongoing injury" to the right ankle on March 18, 1991. The denial was later rescinded by stipulation of October 18, 1991. Although claimant was given numerous diagnoses during the course of his claim, the primary diagnosis remained achilles tendonitis. Claimant underwent surgical exploration of the right achilles tendon on October 23, 1991. His right foot continued to be symptomatic, however.

In June 1992, claimant was referred to an orthopedist, Dr. Woll. Dr. Woll diagnosed right retrocalcaneal bursitis secondary to a right Haglund deformity. Dr. Woll described the Haglund's deformity as a prominence on the posterior aspect of claimant's right heel that was impinging on the achilles tendon with dorsiflexion of the foot.

Dr. Woll subsequently requested authorization for a Haglund's resection to relieve the chronic inflammation of claimant's achilles tendon. On August 21, 1992, the insurer denied the surgical request, as well as the Haglund's deformity, on the grounds that claimant's original injury was not the major contributing cause of the Haglund's deformity and need for treatment. Despite the denial, claimant underwent the Haglund's resection in October 1992.

During the course of litigation concerning claimant's appeal of the insurer's August 1992 denial, Dr. Woll was deposed. In his deposition, Dr. Woll used the term "Haglund's syndrome" to describe claimant's right foot condition. Specifically, Dr. Woll referred to this condition as the "constellation" of the Haglund's deformity and the inflammation of claimant's retrocalcaneal bursa and achilles tendon. At the hearing, the insurer orally denied the compensability of the Haglund's syndrome. A written partial denial of this condition was later issued on February 10, 1993, alleging that neither claimant's original injury nor his work activities were the major contributing cause of the Haglund's syndrome.

CONCLUSIONS OF LAW AND OPINION

The Referee held that the insurer had issued a "back-up" denial when it denied the compensability of the Haglund's syndrome. Reasoning that, when the insurer rescinded its general denial of claimant's right foot condition, it accepted all possible causes of claimant's right foot problems, the Referee found that it had accepted the condition subsequently diagnosed as Haglund's syndrome. Accordingly, the Referee concluded that the insurer had the burden of proving by clear and convincing evidence that claimant's Haglund's syndrome was not compensable. See ORS 656.262(6). Finding that the insurer had failed to do so, the Referee determined that the Haglund's syndrome was compensable.

In addition, the Referee determined that claimant's foot surgery was compensable, even though claimant had conceded that the Haglund's deformity was not compensable, because it was treatment necessary to treat claimant's compensable right foot condition. See Williams v. Gates, McDonald, 300 Or 278 (1985). The Referee, however, did uphold the August 1992 denial of the Haglund's deformity.

Finally, the Referee refused to assess a penalty for an allegedly unreasonable denial of the Haglund's syndrome. The Referee concluded that the insurer's "back-up" denial was not unreasonable, given that the Referee had initially determined that the insurer's denial of his condition did not constitute a "back-up" denial but then subsequently reversed her position.

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

Claimant initially contends that the Referee erred in not assessing a penalty for unreasonable denial of his Haglund's syndrome, citing Laurie A. Bennion, 45 Van Natta 829 (1993). In Bennion, we held that the evidence necessary to establish legitimate doubt supporting a reasonable "back-up" denial is more demanding than that necessary to support the reasonableness of a denial of an unaccepted claim. Id. Asserting that the stricter standard of Bennion should apply because the Referee found that the insurer had issued a "back-up" denial of his Haglund's syndrome, claimant argues that the insurer could not have had reasonable doubt regarding its liability for his right foot condition, given that it had to prove its case by clear and convincing evidence. We agree.

Although Dr. Woll testified that claimant's work would not have caused his tendonitis and bursitis in the absence of the noncompensable Haglund's deformity, he also stated that claimant's work activities worsened the achilles tendonitis and retrocalcaneal bursitis. (Tr. 21). Dr. Woll further testified that claimant's work did lead to inflammation, soft tissue swelling, and heterotopic changes in the achilles tendon. (Tr. 14). While claimant's employment did not worsen the deformity, Dr. Woll's testimony establishes that repetitive work activities involving dorsiflexion of the foot worsened other components of the Haglund's syndrome.

Considering the insurer's ultimate burden to prove noncompensability of the Haglund's syndrome by clear and convincing evidence, we do not find that Dr. Woll's testimony reasonably approaches this standard. Accordingly, we conclude that the insurer did not have a legitimate doubt about its liability for claimant's occupational disease claim. We, therefore, disagree with the Referee's conclusion that the insurer's "back-up" denial of claimant's Haglund's syndrome was reasonable.

Claimant also contends that the insurer's denial of his Haglund's resection surgery was also unreasonable. Conceding that the Haglund's deformity itself is not compensable, claimant nevertheless asserts that the insurer's denial was unreasonable because Dr. Woll's medical reports clearly established that the surgery was necessary in order to treat his compensable right foot condition. See Williams v. Gates, McDonald, supra.

We agree that Dr. Woll's medical reports persuasively establish that claimant's surgery for the noncompensable Haglund's deformity was necessary in order to treat the compensable component of the claim. (Exs. 37, 38, 39, 41). The surgery, as the Referee found, was clearly compensable under Williams. The insurer argues that the enactment of ORS 656.005(7)(a)(B) effectively overruled Williams, thereby giving it a reasonable basis to deny claimant's surgery.

The insurer cites no authority for its proposition. Moreover, we have held that ORS 656.005(7)(a)(B) does not apply to occupational disease claims such as this one. See Lizbeth Meeker, 44 Van Natta 2069 (1992). While the insurer's August 1992 denial of claimant's surgery preceded our decision in Meeker, there was no medical evidence prior to the insurer's denial which established that claimant's preexisting Haglund's deformity "combined" with his compensable right foot condition to cause a need for treatment. See ORS 656.005(7)(a)(B). Accordingly, we do not find the insurer's denial of claimant's surgery to have been reasonable.

In conclusion, we find the insurer's denials of claimant's Haglund's syndrome and the Haglund's resection surgery to have been unreasonable. However, only one 25 percent penalty may be assessed against claimant's compensation. See Conagra, Inc., v. Jeffries, 118 Or App 373, 376 (1993). We, therefore, assess one 25 percent penalty pursuant to ORS 656.262(10) for the insurer's unreasonable denial of the Haglund's syndrome, to be shared equally by claimant and his counsel. This penalty shall be based on all amounts of compensation, including medical services, due at the time of the hearing as a result of the Referee's order. Ben G. Santos, 44 Van Natta 2228 (1992), on recon 44 Van Natta 2385, 2386 (1992).

Moreover, the issue of whether claimant's Haglund's syndrome is compensable is different from the issue of whether claimant's Haglund's resection surgery, which was necessary to treat a compensable condition, was itself compensable. Therefore, the insurer's unreasonable denial of the Haglund's syndrome was conduct separate and distinct from its unreasonable denial of the Haglund's resection surgery. Consequently, claimant is entitled to an assessed attorney fee under ORS 656.382(1) for its unreasonable denial of the Haglund's surgery. Glenn R. Nash, 45 Van Natta 942 (1993).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that a reasonable fee for claimant's attorney's services regarding the insurer's unreasonable resistance to the payment of compensation (its denial of the resection surgery) 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 May 3, 1993, as modified on June 28, 1993, is reversed in part and affirmed in part. That portion which declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable denials is reversed. For the insurer's unreasonable Haglund's syndrome denial, claimant is awarded a penalty equal to 25 percent of the compensation due at the time of the hearing as a result of the Referee's order, to be shared equally by claimant and his attorney. For the insurer's unreasonable surgery denial, claimant's counsel is also awarded a separate assessed attorney fee of $500, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RUBY L. GOODMAN, Claimant
WCB Case No. 92-03824
ORDER ON REVIEW (REMANDING)
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board en banc.

Dr. Moore, the injured worker's medical services provider, requests review of Referee Baker's order that affirmed a Director's order under ORS 656.327(2) finding that the injured worker's chiropractic treatments were inappropriate. Dr. Moore requests remand to the Referee for fact finding. We have reviewed the request to determine whether we have jurisdiction to consider the matter. On review, the issues are jurisdiction and, alternatively, remand and review of a Director's order in a medical treatment dispute. We conclude that we have jurisdiction, and we remand.

FINDINGS OF FACT

On April 1, 1991, the insurer requested Director review concerning the propriety of the injured worker's January and February, 1991 chiropractic treatments with Dr. Moore. The Director issued an order concluding that the treatments were not appropriate. Dr. Moore requested a hearing concerning the Director's order. Reviewing for substantial evidence, the Referee affirmed the Director's order. Dr. Moore requested Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Before we proceed to the merits of this claim, we must determine whether we have jurisdiction to review this matter. The issue we are faced with is whether a medical service provider is entitled to request Board review of a referee's order in a medical services dispute governed by ORS 656.327(2). We conclude that the answer is "yes."

This issue involves a question of statutory interpretation. Accordingly, our duty is to divine the legislature's intent. To accomplish this task, we examine both the text and context of the statutory scheme. See Julie Sturtevant, 45 Van Natta 2344 (1993) (citing Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526, 533 (1993)).

ORS 656.327(1) authorizes the Medical Director to review the propriety of an injured worker's medical services if the injured worker, the carrier or the Director wishes such review. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). The Director has up to 40 days after a request for such review to issue an order based on findings regarding the treatment in question. See ORS 656.327(2). ORS 656.327(2) further provides that,

> "[i]f 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 * * *." (Emphasis added.)

ORS 656.283(1) provides that any "party" may at any time request a hearing on any question concerning a claim. Thereafter, the referee has 30 days to make an order regarding the matter. ORS 656.289(1). That 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).

In the workers' compensation context, a "party" generally means "a claimant for compensation, the employer of the insured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(20). That definition does not include a medical service provider. However, under ORS 656.327(2), a medical service provider may be a dissatisfied "party." This conflict creates a statutory ambiguity. Accordingly, we turn to the context of the statute to determine legislative intent. See ORS 656.003 (The definitions in ORS Chapter 656 govern its construction, "[e]xcept where the context otherwise requires[.]").

ORS 656.327 was enacted in 1987. Or Laws 1987, ch 884, § 29. At the time, the legislature determined that injured workers, carriers and medical service providers were authorized to request review of the Director's order pursuant to ORS 656.283. The natural derivative of such a hearing request is a referee's order under ORS 656.289 and the Board review procedures of ORS 656.295. Obviously, the legislature intended to put medical service providers in the forefront of medical service disputes.

Neither the 1987 nor subsequent legislatures have amended the general definition of "party" to include medical service providers. It is apparent that the legislature intended that, for most purposes, the term "party" would retain its usual definition, but that in the medical services dispute context, the term "party" would include medical service providers. See ORS 656.327(2); see also James v. Carnation Co., 278 Or 65, 74 (1977) (statutory phrase may have different meanings when used in different contexts).

It would be anomalous to conclude that a medical service provider would be a "party" for purposes of requesting a hearing under ORS 656.327(2), only to lose that status once a referee's order issued. See Russell v. SAIF, 29 Or App 295 (1977), rev'd on other grounds 281 Or 353, on remand 33 Or App 153 (1978) (incongruous result from a suggested construction of a statute indicates that such construction was not the legislature's intent). Accordingly, we conclude that, by amending ORS 656.327(2), the legislature intended to give medical service providers in medical services disputes the same appeal rights as any other "party," which includes the right to Board review of a referee's order.

The dissent argues that, because ORS 656.005(20)'s definition of "party" does not include medical service providers, and because only a "party" may request Board review of a referee's order, see ORS 656.005(20), ORS 656.289(3), ORS 656.295, we lack jurisdiction to review this Referee's order. As support for that reasoning, the dissent relies on Karen K. Vansanten, 40 Van Natta 63 (1988), where we held that a worker's treating physician is not a "party" for purposes of ORS 656.005(20).[1] The dissent's analysis is untenable.

The dissent ignores ORS 656.003, which specifically directs us to consider the context in which a particular statutory term appears. Furthermore, the dissent's reliance on Karen K. Vansanten is misplaced. That case did not concern ORS 656.327. Moreover, it was issued well before the legislature amended ORS 656.327(2) in 1990. Therefore, even if Vansanten were applicable, we would question its continued validity in light of the intervening amendment to ORS 656.327(2).

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[1] Vansanten was decided under former ORS 656.005(19), which was renumbered ORS 656.005(20) in 1990. Or Laws 1990, ch 2, § 3.

In sum, we conclude that, in medical service disputes governed by ORS 656.327, a medical service provider is entitled to seek Board review if the provider is dissatisfied with a referee's order concerning a Director's medical services order.[2] Accordingly, we have jurisdiction to review this Referee's order. We now proceed with our review.

Remand

Reviewing for substantial evidence under ORS 656.327(2), the Referee affirmed the Director's order finding that the disputed chiropractic treatment was not appropriate for the worker's compensable condition. Dr. Moore argues that remand is appropriate, because the Referee erroneously limited his review to the record developed before the Director in reliance on Iola W. Payne-Carr, 45 Van Natta 335 (1993), aff'd Payne-Carr v. Oregon Portland Cement Company, 126 Or App 314 (1994), where we held that referee review of a Director's order under ORS 656.327(2) was limited to the record developed before the Director. We agree.

Subsequent to the Referee's order, we disavowed our holding in Iola W. Payne-Carr. In Julie Sturtevant, supra, we reexamined the issue presented in Payne-Carr and concluded that, on the basis of the text and context of ORS 656.327(2), the legislature intended referees to find facts independently based on an evidentiary record developed at hearing. Id. at 2347.[3]

In light of Sturtevant, we conclude that the Referee's review was not limited to the record developed before the Director. Rather, the parties were entitled to a hearing before the Referee, during which they could present evidence, including testimony; thereafter, the Referee would find facts independently from which to conclude whether the Director's order was supported by substantial evidence in the whole record. Id.

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

We have previously ruled that, where the evidence at hearing was limited to that developed before the Director and the parties presented their respective positions under an erroneous standard of review, there is a compelling reason to remand. See Patricia D. Simmons, supra; see also Peter Britz, 45 Van Natta 2187 (1993). We have adhered to this ruling even when additional evidence was presented at hearing, but not considered by the referee. See Lois J. Schoch, 46 Van Natta 157 (1994).

We conclude that there is a compelling reason to remand this case. Although the parties litigated this matter under the correct standard of review ("substantial evidence" under ORS 656.327(2)), they, and the Referee, proceeded under the erroneous belief that the Referee's review was limited to the record developed by the Director. Moreover, the parties presented additional evidence at hearing; however, they have failed to identify, and we are unable to ascertain the identity of, that evidence on review. Under the circumstances, we conclude that the record is incompletely developed and that there is a compelling reason to remand. ORS 656.295(5); see Patricia D. Simmons, supra; Lois J. Schoch, supra.

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[2] As further support for our conclusion, we note that ORS 656.327(1)(b) provides that a Board decision regarding the Director's order that no bona fide medical services dispute exists "is not subject to review by any other court or administrative agency." Had the legislature intended to limit the appellate rights of medical service providers under ORS 656.327(2), it likely would have done so in a manner similar to that expressed in ORS 656.327(1)(b).

[3] In Iola W. Payne-Carr, this Board alternatively found that, even assuming that the Board considered the additional evidence that the claimant had submitted, the result would have been the same. Id. at 337. The Court of Appeals affirmed Iola W. Payne-Carr without opinion on February 19, 1994. Payne-Carr v. Oregon Portland Cement Company, 126 Or App 314 (1994). The court's affirmance could have been based on either the Board's conclusion that referee review of a Director's order under ORS 656.327(2) is limited to the record developed before the Director, or the Board's alternative finding which considered the additional evidence. Because Sturtevant has rejected the "additional evidence" prohibition of Payne-Carr, and because we do not interpret the court's affirmance of Payne-Carr as necessarily inconsistent with Sturtevant, we will continue to follow Sturtevant.

Accordingly, we remand this matter to Referee Podnar for further proceedings consistent with this order. At the further proceedings, the parties may present evidence regarding the propriety of Dr. Moore's chiropractic treatments. See Lois J. Schoch, supra; see also Ronald J. Lombard, 46 Van Natta 49 (1994).

ORDER

The Referee's order dated May 17, 1993 is vacated. This matter is remanded to Referee Baker for further action consistent with this order. The Referee may conduct these further proceedings in whatever manner the Referee determines achieves substantial justice.

Board Member Hall specially concurring.

I concur with the majority's conclusion that a medical service provider is entitled to seek Board review of a Referee's order resulting from a hearing under ORS 656.327(2). I write separately to clarify my reasoning for such a conclusion.

ORS 656.327(2) expressly authorizes a medical service provider, as a "dissatisfied party," to request a hearing regarding the Director's order. Inasmuch as the statute specifically recognizes the medical service provider as a "party," I submit that ORS 656.327(2) takes precedence over the general definition of "party" under ORS 656.005(20).

Moreover, in establishing review procedures for the Director's order, ORS 656.327(2) refers to ORS 656.283 and the Board's expedited hearing procedures. In light of such a directive, it is apparent that, within the context of ORS 656.327(2), a medical service provider is a "party," who is entitled to request a hearing under ORS 656.283.

ORS 656.283 does not set forth the appellate procedures which result from the Referee's eventual order. Instead, ORS 656.289(3) and ORS 656.295(1) and (2) detail the manner in which Board review is requested. These provisions clearly envision a party to the proceeding before the Referee as being authorized to request review. Since a medical service provider is a "party" for purposes of requesting a hearing under ORS 656.283, that provider likewise retains that designation for purposes of seeking review of the Referee's order.

In conclusion, based on the aforementioned reasoning, I concur with the majority opinion which has determined that we retain jurisdiction to consider the medical service provider's appeal and that remand for further proceedings is warranted.

Board Member Haynes and Chair Neidig dissenting.

We disagree with the majority's conclusion that we have jurisdiction to address Dr. Moore's request for review. Accordingly, we dissent.

As the majority correctly states, this Board's duty is to ascertain the legislature's intent with respect to a medical service provider's Board review rights under ORS 656.327(2). That duty does not include the authority to alter the express terms of the statute. See Allen v. State Ind. Acc. Com., 200 Or 521 (1954). Furthermore, because this Board has no legislative powers, it is not authorized to correct any deficiencies in the statutory language so as to better serve what the Board feels was, or should have been, the legislature's intent. See Monaco v. U.S. Fidelity & Guar. Co., 275 Or 183 (1976); see also Dilger v. School District 24CJ, 222 Or 108 (1960) (courts cannot, in the guise of construction, supply an integral part of the statutory scheme omitted by the legislature). Yet, that is exactly what the majority does here.

ORS 656.327 authorizes the Director to issue an order regarding the propriety of an injured worker's medical services. ORS 656.327(1), (2). ORS 656.327(2) provides, in part:

> "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 * * *."

ORS 656.283(1) provides that any "party" may request a hearing before a referee. The referee's order becomes 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).

So, who is a "party"? The legislature has already answered that question: A "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). Absent a clear manifestation of legislative intent to the contrary, that definition will apply throughout the Act. See ORS 656.003; see also Chapman Bros. v. Miles-Hiatt Investments, 282 Or 643 (1978).

There is no such clear manifestation of contrary legislative intent here. When the 1987 Legislature enacted ORS 656.327(2), it authorized a medical service provider to request a hearing regarding a Director's medical services dispute order in accordance with ORS 656.283. Or Laws 1987, ch 884, § 29. Therefore, the legislature obviously intended that, as it is used in ORS 656.327(2) and ORS 656.283, in medical services disputes, the term "party" would include medical service providers. See ORS 656.003.

In amending the Act in 1987 and subsequently, however, the legislature left untouched ORS 656.005(20)'s general definition of "party." There is absolutely no indication that the legislature intended that, in medical services disputes or otherwise, anything other than ORS 656.005(20)'s definition of "party" was to be used in ORS 656.289 and ORS 656.295, the statutes that govern requests for Board review of referee orders. It follows that the general definition of "party" applies to those statutes.

This Board has previously held that, for purposes of ORS 656.005(20),[1] a worker's treating physician is not a party. See Karen K. Vansanten, 40 Van Natta 63 (1988). Because ORS 656.005(20)'s definition of "party" applies to ORS 656.289 and ORS 656.295, and because ORS 656.005(20), on its face and as applied by this Board, does not include a medical service provider, I would conclude that Dr. Moore is not a "party." Accordingly, he cannot validly request Board review. See ORS 656.289(3); ORS 656.295. For these reasons, we would hold that we lack jurisdiction to consider Dr. Moore's request for review.

In reaching this conclusion, we note that ORS 656.327(2) authorizes a medical service provider who is dissatisfied with a Director order regarding the propriety of medical services to request a hearing on the order. However, we have found no legislative authorization for a medical service provider to request Board review of a referee's order. To the contrary, the sole statutory directive identifying the individuals or entities who may seek Board review of referees' orders expressly refers to those individuals and entities as "parties." See ORS 656.289(3); ORS 656.295. Since a medical service provider is not included in that statutory class, see ORS 656.005(20), we would hold that we are not authorized to consider the injured worker's chiropractor's current request for review.

It may logically follow that, because a medical service provider may request a hearing from a Director's order under ORS 656.327(2), that provider may likewise appeal a referee's order resulting from that hearing request. However, there is no statutory support for such reasoning. To the contrary, as we have already stated, the statutes pertaining to review of referees' orders are confined to a select class of individuals and entities that does not include medical service providers.

As the majority observes, amended ORS 656.327(2) has created something of an anomaly, in that it authorizes a medical service provider to request a hearing, but no more. That anomaly appears to be the result of a legislative oversight. Because we are not at liberty to correct such oversights, see Monaco v. U.S. Fidelity & Guar. Co., supra, Dilger v. School District 24CJ, supra, we cannot join the majority. Accordingly, we respectfully dissent.

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[1] Vansanten was decided under former ORS 656.005(19), which was renumbered ORS 656.005(20) in 1990. Or Laws 1990, ch 2, § 3.

In the Matter of the Compensation of
ROBERT L. MOWRY, Claimant
WCB Case No. 92-12620
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Black's order that affirmed a Director's order dismissing claimant's request for vocational assistance. On review, the issue is vocational assistance. We affirm.

FINDINGS OF FACT

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

By September 1990, claimant had withdrawn from vocational training because his wife's terminal illness and his own health problems prevented meaningful participation.

CONCLUSIONS OF LAW AND OPINION

Following a 1974 compensable back injury, claimant's aggravation rights expired on November 8, 1983. Claimant began receiving vocational assistance when the 1974 injury claim was reopened for surgery in 1986. The vocational program was interrupted for treatment of other medical problems, then resumed again in 1989. By September 1990, claimant had withdrawn from vocational training because his wife's terminal illness and his own health problems prevented meaningful participation.

Although claimant requested that vocational services be suspended "temporarily," his vocational counselor reported claimant's willingness to "chance" his ability to receive vocational assistance in the future. (Exs. 33, 34). The insurer informed claimant's attorney that it would be "amenable to [claimant's] reentry into vocational assistance at a later date if [claimant] chose to decline services at this time." (Ex. 35-2).

Vocational assistance was terminated formally on September 28, 1990. Claimant was notified of his right to appeal that termination within 60 days. See ORS 656.283(2).

In March 1992, claimant requested additional vocational assistance. (Exs. 37, 39). The insurer refused to reinstate vocational services, because claimant's aggravation rights had expired and his prior services had been formally terminated.

Claimant sought and obtained administrative review of the insurer's ineligibility determination. The Department dismissed claimant's request for vocational assistance with prejudice, finding claimant ineligible for vocational services because his aggravation rights had expired. See Harsh v. Harsco Corporation, 123 Or App 181 (1993).[1]

Claimant argues that the insurer should be estopped from refusing to reinstate vocational services, because the insurer led him to believe that the 1990 program was only temporarily terminated. We disagree.

Equitable estoppel may be asserted against insurers or employers in workers' compensation cases. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159, 163 (1992) (Where the employer's act of telling claimant and her doctor to proceed with surgery caused claimant to change her position in reliance on employer's conduct, equitable estoppel operated so as to require employer to pay claimant's expenses of surgery); Lamarr H. Barber, 42 Van Natta 292 (1991).

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[1] Even assuming that claimant could be eligible for vocational services under ORS 656.340 (despite his Own Motion status), he would nonetheless be subject to the requirements for reinstatement of vocational services after an ineligibility determination. See OAR 436-120-055(2). Because it was previously determined that claimant could not benefit from vocational services for personal reasons, those conditions must have since changed such that claimant could benefit from assistance, for him to be currently entitled to vocational services. See OAR 436-120-055(2)(a). Since the record does not support a conclusion that claimant's condition has changed since the prior termination of vocational services, we would be forced to conclude that claimant has not proven entitlement to vocational assistance.

"To constitute an equitable estoppel, or estoppel by conduct, (1) there must be a false representation; (2) it must be made with knowledge of the facts; (3) the other party must have been ignorant of the truth; (4) it must have been made with the intention that it should be acted upon by the other party; and (5) the other party must have been induced to act upon it." Bennet v. City of Salem, 192 Or 531, 541 (1951). The doctrine may be applied "when conduct is 'misleading,' even if it is innocent." Swift & McCormick Metal Processors Association, Inc. v. Durbin, 117 Or App 605 (1993). However, in Stovall v. Sally Salmon Seafood, the Supreme Court cautioned: "'The doctrine of estoppel is only intended to protect those who materially change their position in reliance upon another's acts or representations.'" 306 Or 25, 34 (quoting Bash v. Fir Grove Cemeteries, Co., 282 Or 677, 687 (1978)).

In this case, the parties stipulated that claimant participated in services to develop an approved authorized training program until September 26, 1990, when he requested that the program be placed in temporary interrupt status because his wife was terminally ill and he was having additional health problems of his own which required surgery. (See stipulated fact number 10, incorporated by reference from claimant's May 19, 1993 closing argument, Opinion and Order p. 1).

Claimant asserts that he relied on the employer's "promise" to reinstate vocational services in the future, when he withdrew from the program voluntarily. We find no evidence to that effect. Specifically, we find no evidence that suggests that claimant withdrew from the program for any reason other than his inability to fully participate. Claimant has the burden of proof. On this record, we find that it is more likely that claimant stopped participating in the vocational assistance program because of his wife's terminal illness and his own health problems. (See Exs. 26-32; see also Ex. 39).

Under these circumstances, we conclude that claimant has not established that he was "induced" to act (to agree to termination of vocational assistance) by the insurer's alleged promise (to reinstate such assistance in the future). In other words, on this record, we cannot say that claimant changed his position in reliance on the insurer's conduct. See Stovall v. Sally Salmon Seafood, supra; Meier & Frank Co. v. Smith-Sanders, supra. Accordingly, we conclude, as did the Referee, that claimant has not proven that the insurer should be estopped from denying reinstatement of vocational services for claimant.

ORDER

The Referee's order dated July 12, 1993 is affirmed.

In the Matter of the Compensation of
ANGELA M. STRATIS, Claimant
WCB Case Nos. 93-03339 & 92-16578
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Mitchell, Lang, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Crawford & Company, on behalf of Kimerly Quality Care Center, requests review of that portion of Referee McWilliams' order that assessed an attorney fee against it rather than the SAIF Corporation, on behalf of Touchmark Living Center. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, after finding claimant's right shoulder compensable, assigned responsibility for the condition to Crawford. The Referee also ordered Crawford to pay an assessed attorney fee of $3,200.

Crawford asserts that, because it denied only responsibility and SAIF denied compensability as well as responsibility, SAIF should be liable for the assessed attorney fee. SAIF responds that its denial was limited to responsibility and, if its denial is construed as including compensability, Crawford's denial should be interpreted in the same manner.

We agree with Crawford that SAIF denied compensability. SAIF's denial stated that information indicated that claimant's accepted condition was no longer the major contributing cause for her current need for treatment, as well as providing a list of potential responsible employers. (Ex. 142). Furthermore, the letter stated that it had not requested a paying agent pursuant to ORS 656.307. (Id.) Finally, the letter included the notice required for disclaimers of responsibility and denials of compensation. See OAR 438-05-053(4). Under these circumstances, we find that SAIF's letter contested causation and, therefore, denied compensability as well as responsibility.

Crawford's first letter provided that "it does appear that your current medical condition is a compensable injury; however, we do not feel that [Crawford] is the responsible insurer." (Ex. 119). The letter also indicated that Crawford had requested the appointment of a paying agent pursuant to ORS 656.307 "as this is only a denial for responsibility" and provided a notice that, under OAR 438-05-053(3), must be provided for disclaimers of responsibility. We find no indication in this letter that Crawford denied compensability and, therefore, we conclude that it was limited to responsibility.

The more difficult question is whether Crawford expanded its denial in a second letter to include a denial of compensability. This letter indicated that claimant's current need for treatment was caused by prior injuries with previous employers and provided a list of those employers. (Ex. 137-1). Again, it provided that Crawford had requested a paying agent. (Id. at 2). However, it also contained the notice required by OAR 438-05-053(4) pertaining to disclaimers of responsibility and denials of compensability. Thus, although the text of Crawford's second letter is most reasonably construed as denying only responsibility, the inclusion of the notice is evidence of a compensability denial. See Johnny M. Davis, 45 Van Natta 2282 (1993).

At hearing, claimant's counsel stated that she was appealing Crawford's "responsibility denials" as well as SAIF's "compensability, responsibility denial." (Tr. 2). There was no objection to this statement of the issues. (Id. at 3).

In Davis, we concluded that a carrier had denied the compensability of a claim when it included a notice under OAR 438-05-053(4), as well as a statement in the notice that the carrier was not "waiving other issues of compensability." Here, unlike the carrier in Davis, Crawford did not indicate that it was not "waiving other issues of compensability." Furthermore, as acknowledged by claimant's attorney at the hearing, Crawford's denial was characterized as only relating to responsibility. This characterization was unchallenged by any party at the hearing. Under these circumstances, despite the inclusion of the OAR 438-05-053(4) notice in the denial letter, we find the record shows that Crawford's denial was limited to responsibility. Consequently, Crawford is not responsible for the attorney fee assessed at hearing. See e.g. Safeway Stores, Inc. v. Hayes, 119 Or App 319, 323-24 (1993).

Claimant's attorney further contends that, based on the Board's de novo review, compensation remained at risk on review and, thus, she is entitled to a fee for services on review. Even if we agreed with the asserted grounds for awarding such a fee, because the issue on review solely concerns attorney fees, there is no entitlement to an award for services on review. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated August 30, 1993 is reversed in part and affirmed in part. The Referee's attorney fee award of $3,200 is assessed against the SAIF Corporation, on behalf of Touchmark Living Center, rather than Crawford & Company, on behalf of Kimerly Quality Care Center. The remainder of the order is affirmed.

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case Nos. 92-11012 & 92-10411
SECOND ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

On March 28, 1994, we issued an Order on Reconsideration which increased claimant's carrier-paid attorney fee award for her counsel's efforts in obtaining a pre-hearing rescission of the SAIF Corporation's "de facto" denial of an adhesive capsulitis condition from $150, as granted by our February 4, 1994 Order on Review, to $500. In reaching such a conclusion, we noted that we had not received a timely response from SAIF concerning claimant's motion for reconsideration.

Following issuance of our reconsideration order, SAIF's response (which was hand-delivered to our Salem office on March 18, 1994) was brought to our attention. Although received in timely compliance with the schedule implemented in our March 4, 1994 Order of Abatement, SAIF's response was initially misdirected to another Board file.

In light of such circumstances, we treat SAIF's response as a motion for reconsideration of our March 28, 1994 Order on Reconsideration. In order to further consider this matter, we withdraw our prior orders. Claimant is granted an opportunity to respond. To be considered, claimant's response must be received 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
ALEC B. BEKEBREDE, Claimant
WCB Case No. 93-05224
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Menashe's order that upheld the insurer's denial of claimant's occupational disease claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation. Dr. Weintraub, orthopedic surgeon, treated claimant twice in January 1993. After a MRI revealed a large herniated disc at C5-6, Dr. Weintraub referred claimant to Dr. Rosenbaum, neurosurgeon, for further treatment. (Ex. 9).

Dr. Rosenbaum opined that it was possible that claimant's work activities were a contributing factor to his herniated cervical disc. (Exs. 20, 22). However, the "possibility" of a causal relationship is insufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

Furthermore, although Dr. Weintraub opined that claimant's work activity was the major contributing cause of claimant's cervical condition, Weintraub had an inaccurate history regarding the onset of claimant's cervical symptoms. (Exs. 9-1, 15, 20A). Dr. Weintraub recorded a history that claimant noticed pain in his right side of his neck and his right shoulder and arm "after lifting many numbers of kegs and boxes above his head." (Ex. 9-1). Dr. Weintraub relied on that history in opining that the the major contributing cause of claimant's cervical condition was his work activities and in ruling out a degenerative condition as possibly being "the actual underlying anatomical problem." (Exs. 15, 20A).

However, claimant consistently reported to all of the other physicians who examined him and at hearing that he awoke early one morning, about December 10, 1992, with severe pain in his right neck, shoulder and arm. (Exs. 2, 10-1, 16-2, Tr. 15). Both Drs. Duff, examining orthopedist, and Rosenbaum had an accurate history of claimant awaking one morning with severe pain. (Exs. 10-1, 16-2).

Of the medical reports that contain an accurate history of the onset of claimant's cervical symptoms, Dr. Rosenbaum's opinion is the most supportive of claimant's claim. However, as discussed above, Dr. Rosenbaum was able to give no stronger opinion than that it was possible that the work activities were a cause of claimant's cervical condition. That is insufficient. Furthermore, because Dr. Weintraub had an inaccurate history as to the onset of claimant's symptoms, we agree with the Referee that his opinion is not persuasive. Consequently, claimant has failed to establish that his cervical condition is compensable.

ORDER

The Referee's order dated August 10, 1993 is affirmed.

Board Member Gunn, dissenting.

Because I would rely on the opinion of Dr. Weintraub, treating orthopedic surgeon, I respectfully dissent. Dr. Weintraub is aware that claimant's job requires frequent lifting of kegs and boxes above his head. It is his opinion that this overhead lifting, including the neck positions that such lifting caused, is the major contributing cause of claimant's cervical condition. (Exs. 9-1, 15, 20A).

In addition, I do not find Dr. Duff, examining orthopedist, to be persuasive. Dr. Duff is employed by Medical Consultants Northwest and examined claimant on March 10, 1993, at the insurer's request. Without explanation, Dr. Duff concluded that the major contributing cause of claimant's cervical condition is a "degenerative process in the cervical disc with apparently a spontaneous herniation." (Ex. 16-6). However, neither the x-ray report nor the MRI report show any evidence of any "degenerative process." (Exs. 3, 9A). Furthermore, none of the medical reports indicates that claimant suffers from any "degenerative process."

The only other mention of any degenerative condition is made by Dr. Weintraub. However, Dr. Weintraub does not opine that claimant has a degenerative condition; instead, he rules out the possibility of a "degenerative condition." (Ex. 20A). He does so in reference to a report from "Orthopedic Consultant's" and "Dr. Best's conclusions." Id. However, the record contains no report from "Orthopedic Consultants" or "Dr. Best."

Given the fact that the medical record, including the medical tests, does not indicate that claimant suffered from any degenerative condition, there is no evidence that claimant suffered from such a condition. Dr. Duff's conclusion to the contrary is not persuasive.

I agree with my colleagues that Dr. Rosenbaum, consulting neurosurgeon, provides no more than a possibility that claimant's work activities caused claimant's cervical condition and that a possibility is insufficient to meet claimant's burden of proof. (Exs. 20, 22). However, Dr. Rosenbaum's opinion, although not itself sufficient to establish causation, supports Dr. Weintraub's opinion. (Exs. 9-1, 15, 20A).

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 defer to the opinion of Dr. Weintraub.

On this record, I find that claimant has established, by a preponderance of the medical evidence, that his work activities were the major contributing cause of his cervical condition.

In the Matter of the Compensation of
BARBARA G. BENNETT, Claimant
WCB Case No. 93-01784
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Holtan's order which: (1) reduced claimant's award of unscheduled permanent disability for an upper back and neck injury from 35 percent (112 degrees), as granted by an Order on Reconsideration, to 22 percent (70.4 degrees); (2) declined to penalize the SAIF Corporation for allegedly unreasonable claim processing; and (3) awarded claimant's attorney an assessed attorney fee of $250. On review, the issues are extent of unscheduled permanent disability, penalties and attorney fees.

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

The Referee declined to award a penalty for SAIF's alleged failure to timely pay medical bills because the record did not reflect when SAIF received the billings. If a claimant fails to establish when an insurer received disputed medical bills, no penalty may be assessed for alleged untimely payment of medical billings. See Daniel R. Muller, 43 Van Natta 1662, 1663 (1991). Since the record does not disclose when SAIF received the medical bills in question, the Referee properly refused to assess a penalty for SAIF's allegedly unreasonable claims processing.

ORDER

The Referee's order dated July 23, 1993 is affirmed.

In the Matter of the Compensation of
STEVEN FURNISH, Claimant
WCB Case No. 91-04257
ORDER ON REMAND
Vick & Gutzler, Claimant Attorneys
James Dodge (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Furnish v. Montavilla Lumber Company, 124 Or App 622 (1993). The court reversed our prior order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition. Despite adopting a referee's findings of fact (which included a finding that claimant's work activities involved repetitive lifting and climbing), in our conclusions of law, we discounted a medical opinion because it had been "based on [the physician]'s mistaken belief that claimant's work involved repetitive work activities." Reasoning that our findings were contradictory, the court concluded that we must resolve this inconsistency and adequately explain why our findings lead to our conclusion. Consequently, citing Armstrong v. Asten-Hill Company, 90 Or App 200 (1988), the court has remanded for reconsideration.

After conducting our reconsideration, we adhere to the reasoning and conclusions contained in our prior order, with the following supplementation and modification.

As discussed in our prior order, we continue to find that claimant's work involved some lifting, but not repetitive climbing and lifting. Therefore, we expressly do not adopt the Referee's contrary finding that claimant's work activities involved repetitive climbing and lifting.

In order to establish a compensable occupational disease, claimant must prove that employment conditions involved a series of traumatic events that were the major contributing cause of the need for treatment or resulted in disability. ORS 656.802(1)(c). After our review, we are not persuaded that

claimant has established that his work activities were the major contributing cause of his low back condition. Therefore, we continue to conclude that claimant has failed to prove an occupational disease claim under ORS 656.802. We base this conclusion on the following reasoning.

There are two opinions on causation. Dr. Pape, claimant's treating physician, attributes claimant's low back condition to his work activities. We do not find Dr. Pape's opinion particularly persuasive. Dr. Pape explained in a brief paragraph: "It is my opinion from [claimant]'s history that the major contributing cause for his non-specific low back pain was repetitive lifting, that he did while employed at [the insured's]."

Although Dr. Pape purported to consider the nature of claimant's work activity, we have herein found that claimant's work did not involve repetitive activities. Therefore, because it is based on an inaccurate history, we reject Dr. Pape's opinion. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Woolpert, examining physician, does not support a work relationship. However, we do not find Dr. Woolpert's opinion persuasive either. Dr. Woolpert opined that because claimant did not experience any "specific trauma" that caused his back pain, claimant did not sustain an on-the-job injury. Dr. Woolpert explained that: "there is simply not enough documentation to indicate that there was any specific on the job injury . . . which . . . would lead to a low back problem."

Dr. Woolpert's reliance on "trauma" is inconsistent with occupational disease law. See ORS 656.802. Because Dr. Woolpert did not consider whether claimant's work activities were the major contributing cause of his low back condition or need for treatment, we do not find Dr. Woolpert's opinion persuasive.

In light of claimant's degenerative disc disease and disc herniation/bulge, we conclude that the causation of claimant's low back condition is of sufficient medical complexity that we cannot decided it without expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). As neither expert medical opinion is persuasive, we conclude that claimant has failed to prove by a preponderance of the evidence that his work activities are the major contributing cause of his low back condition.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our April 30, 1992 order.

IT IS SO ORDERED.

Board Member Gunn dissenting.

When medical opinion is divided, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Because I find no reason not to defer to the treating doctor's opinion in this case, I respectfully dissent.

Dr. Pape began treating claimant's low back condition on March 18, 1991, when he took a history from claimant that his work involved "a lot of lifting and bending." (Ex. 0-1). Based on claimant's history, Dr. Pape opined that the major contributing cause of claimant's low back pain was repetitive lifting at work. (Ex. 6). Claimant testified that his duties as a truck driver/delivery person involved loading and unloading building supplies and stacking lumber, by hand or with a Hyster. (Tr. 3-4). He described the gradual onset of low back pain as he was performing his usual morning work duties on March 13, 1991. (Tr. 4, 15). Claimant also testified that his work "was very, very busy at that time, more so than we had been for quite some time." (Tr. 16).

Based on my review of the record, I find that claimant's description of his work duties and onset of pain was consistent with the history Dr. Pape recorded and on which he based his opinion. Therefore, I conclude that Dr. Pape's opinion is based on an accurate work history, and I find no reason not to defer to the opinion. Accordingly, I would affirm the Referee's order finding claimant's low back condition compensable.

In the Matter of the Compensation of
GWEN A. JACKSON, Claimant
WCB Case No. 93-01851
ORDER ON RECONSIDERATION
Hollander, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

On March 23, 1994, we withdrew our March 7, 1994 order which: (1) set aside the insurer's "de facto" denial of claimant's proposed bilateral carpal tunnel surgery claim; (2) assessed an attorney fee under ORS 656.382(1) for unreasonable claim processing; and (3) declined to award an attorney fee under ORS 656.386(1) for claimant's counsel's services regarding the surgery claim. We took this action on our own motion to reexamine our conclusion that the court's holding in SAIF v. Allen, 124 Or App 183 (1993), rev allowed 318 Or 478 (1994), precluded claimant from receiving an attorney fee award under ORS 656.386(1) for services devoted to the surgery claim. To assist us in conducting our reconsideration, we granted the parties an opportunity to submit supplemental argument on this issue. Having received those responses, we proceed with our reconsideration.

We begin with a review of the relevant facts. Claimant has a compensable bilateral carpal tunnel and cubital tunnel syndrome condition. Dr. Puziss, her attending physician, requested authorization to perform surgery. The insurer did not respond to this claim within 90 days of the request for authorization. Claimant requested a hearing regarding the insurer's "de facto" denial.

Shortly after claimant's hearing request, the insurer notified Dr. Puziss that it was questioning the need for the requested treatment. Specifically, the insurer was asserting that the proposed surgery was "excessive, inappropriate and ineffectual." Asking for withdrawal of the surgery request, the insurer advised Dr. Puziss that it was prepared to refer the treatment dispute to the Director for resolution. When Dr. Puziss continued to seek surgery authorization, the insurer requested Director review.

Thereafter, claimant's hearing request was heard by the Referee. At hearing, claimant contended that, at a minimum, the insurer had failed to respond to claimant's surgery claim for over 6 months. Characterizing such conduct as a "de facto" denial, claimant argued that the Hearings Division was authorized to consider this claim processing dispute, as well as assess penalties and attorney fees for unreasonable conduct. In response, the insurer asserted that its failure to respond to the surgery request did not constitute a denial of claimant's medical services claim. Noting that "at the heart of the matter is whether or not the surgery is reasonable and necessary in this case," the insurer contended that jurisdiction to resolve the dispute rested with the Director. (Tr. 12).

Inasmuch as claimant's hearing request pertained to a dispute regarding medical treatment, the Referee determined that jurisdiction rested with the Director. Since the penalty and attorney fee issues were linked to resolution of the surgery dispute, the Referee also concluded that jurisdiction over those issues rested with the Director.

Claimant requested Board review. We reversed the Referee's decision. Gwen A. Jackson, 46 Van Natta 357 (1994). Relying on Jefferson v. Sam's Cafe, 123 Or App (1993), we determined that the Hearings Division was authorized to resolve the medical treatment dispute regarding the proposed surgery. Turning to the merits, we found the surgery to be necessary and appropriate treatment.

However, since it was undisputed that the proposed surgery was causally related to claimant's compensable condition, we concluded that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) because the dispute did not pertain to the "compensability" of the claim. As support for our decision, we cited SAIF v. Allen, 124 Or App 183 (1993).

Finally, we considered the insurer's failure to timely respond to the surgery request or seek Director review to have been unreasonable. Inasmuch as there were no "amounts then due" on which to base a penalty under ORS 656.262(10), we awarded a $2,500 carrier-paid attorney fee under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation.

On our own motion, we have withdrawn our decision. Our motive in taking such an action is to reexamine our conclusion that claimant is not entitled to a carrier-paid attorney fee award under ORS 656.386(1).

Resolution of this issue is essentially dependent on our interpretation of three appellate holdings. Those decisions are Shoulders v. SAIF, 300 Or 606 (1986), Short v. SAIF, 305 Or 541 (1988), and SAIF v. Allen, 124 Or App 183 (1993). Therefore, to assist in understanding the basis for each holding, we have summarized the decisions.

In Shoulders v. SAIF, supra, the Supreme Court reversed a Court of Appeals decision which had held that claimant was entitled to a carrier-paid attorney fee under ORS 656.386(1) when a carrier requested Board review of a referee's order finding four conditions compensable and the Board found only two of the conditions compensable. A referee had found four separate conditions to be causally related to the claimant's compensable injury. Consequently, the referee set aside the carrier's denial and awarded a carrier-paid attorney fee. The carrier requested Board review. The Board affirmed the referee's compensability finding regarding two conditions and reversed the referee's other two compensability findings. The Board did not award a carrier-paid attorney fee.

The claimant petitioned the Court of Appeals for judicial review, contending that he was entitled to an attorney fee for services on Board review. The court agreed, relying on ORS 656.386(1). Reasoning that a referee's "compensability" finding is not the same as an award of "compensation," the Court of Appeals concluded that ORS 656.382(2) was not applicable because the latter term is required for application of the statute.

The Supreme Court held that claimant was entitled to a carrier-paid attorney fee for services on Board review, but under ORS 656.382(2), not ORS 656.386(1). In reaching its conclusion, the Supreme Court disagreed with the Court of Appeals reasoning that ORS 656.382(2) was inapplicable because the hearing had related to "compensability" rather than to "compensation" and the statute required that the "compensation awarded to a claimant should not be disallowed or reduced . . ."

Relying on the statutory definition of "compensation" under ORS 656.005(9) (which includes all benefits, including medical services, provided for a compensable injury), the Supreme Court concluded that when a claim is determined to be compensable, medical services must be provided. Shoulders v. SAIF, supra, at page 609 (Emphasis in original). Inasmuch as medical services are defined as "compensation" and necessarily follow from a compensability finding, the Court held that ORS 656.382(2) was applicable.

The Supreme Court also determined that ORS 656.386(1) was not applicable. In doing so, the Court identified three prerequisites for an attorney fee award under ORS 656.386(1): (1) the claimant must initiate the appeal; (2) the decision must be from an order or decision denying, rather than allowing, the claim for compensation; and (3) the claimant must finally prevail on the issue of compensation.

Although the second sentence of ORS 656.386(1) (the "administrative clause" of the subsection) did not expressly repeat the requirements that the claimant appeal "from an order or decision denying the claim for compensation," the Court reasoned that under both clauses of the statute (the "administrative" and "judicial" clauses) a claimant must initiate the review or appeal from an order or decision denying the claim. Inasmuch as the carrier had sought Board review of a referee's order directing acceptance of the claim, the Court concluded that ORS 656.386(1) did not apply.

In Short v. SAIF, supra, the Supreme Court affirmed a Court of Appeals decision which held that, under former ORS 656.388(2) (which had allowed for circuit court review of attorney fee disputes under ORS 656.386(1)), the circuit court was not authorized to modify a Board's attorney fee award under ORS 656.382(2). A referee had set aside a carrier's denial of claimant's aggravation claim, awarded interim compensation, assessed a penalty, and awarded attorney fees (one for unreasonable conduct and one for overturning the denial). The carrier requested Board review, contending that the claim was not compensable or, alternatively, that a later claim reopening date was appropriate. The claimant cross-appealed, seeking an earlier reopening date. The Board affirmed the compensability finding, but extended the reopening date to a later time. The Board also reduced the penalty and related attorney fee, but increased the referee's attorney fee award for prevailing on the denied claim. Finally, the Board awarded a carrier-paid attorney fee for the claimant's counsel's services on review. The claimant sought judicial review, which resulted in the court modifying the claim reopening to an earlier date, reinstating the referee's penalty assessment, and affirming the Board's attorney fee awards. Thereafter, the claimant petitioned the circuit court for an increase in the Board's attorney fee award. When the circuit court increased the award, the carrier appealed.

Reasoning that the claimant had not initiated Board review, the Court of Appeals concluded that ORS 656.386(1) was not applicable. Since ORS 656.382(2) was the applicable statute and because that statute did not provide for circuit court review of attorney fees, the Court of Appeals held that the circuit court was without authority to modify the Board's attorney fee award.

The Supreme Court affirmed. Stating that ORS 656.386(1) provides for attorney fees on review of "denied claims," the Court noted that the claimant had not appealed either to the Board or to the court from a decision "denying her claim." Short v. SAIF, supra, at page 545. To the contrary, the Court pointed out that both the referee and the Board had concluded that the claimant's condition was compensable. The Supreme 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 and the ORS 656.388(2) route to the circuit court is not available." Id. (Emphasis supplied).

Since the claimant had appealed the amount of liability or extent of disability (and concurrently could seek review of the attorney fee award), the Court determined that there was no statutory provision for circuit court review under former ORS 656.388(2). Likewise, the Court reasoned that circuit court review was not obtainable because the attorney fee award arose under ORS 656.382(2) since the carrier had appealed the compensability of the claim or the amount or extent of liability and the compensation awarded to the claimant was not disallowed or reduced.

In SAIF v. Allen, supra, the court reversed a Board order which had held that the claimant was entitled to a carrier-paid attorney fee award under ORS 656.386(1) for obtaining payment (without a hearing) of unpaid medical bills relating to a compensable claim. After being found responsible for claimant's compensable conditions, a carrier paid some outstanding medical bills. When it did not pay other medical bills, the claimant requested a hearing. At the hearing, the parties agreed that the claimant was entitled to a penalty and a related attorney fee award under ORS 656.382(1) because the bills had been untimely paid. The Board also awarded a carrier-paid attorney fee under ORS 656.386(1) because the claimant's attorney had been "instrumental in obtaining compensation" for the claimant without a hearing.

In reversing the Board's order, the court issued a plurality decision. Relying on Shoulders v. SAIF, supra, at page 611 (1986), Judge Leeson 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." Judge Leeson further referred to Short v. SAIF, supra, at page 545 (1988), which included the statement 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 . . ." Reasoning that the "compensability" of claimant's injury was never disputed (but rather the hearing pertained to the nonpayment of some medical bills), Judge Leeson concluded that ORS 656.386(1) was not applicable.

Judge De Muniz filed a concurring opinion. Although agreeing that the claimant was not entitled to an attorney fee award under ORS 656.386(1), Judge De Muniz disagreed with Judge Leeson's "compensability" reasoning.

Noting that "compensation" includes all benefits, including medical services, provided for a compensable injury and that "claim" means a written request for compensation, Judge De Muniz determined that the claimant's attorney's request for payment of the medical bills was a written request for compensation. See ORS 656.005(6) and (8). Nevertheless, reasoning that a "decision denying the claim for compensation" is a prerequisite to an attorney fee award under ORS 656.386(1), De Muniz concluded that the carrier's failure to timely respond or pay the claim in full could not be interpreted as a denial.

In reaching his conclusion, Judge De Muniz relied on Johnson v. Spectra Physics, 303 Or 49, 58 (1987), which 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." Albeit dictum (in that Johnson pertained to whether a carrier's silence constituted acceptance), Judge De Muniz determined that the Supreme Court had indicated that a carrier's failure to timely respond to a claim for compensation could not be construed as a "de facto" denial.

Finally, Judge Rossman dissented. Reasoning that it was only after the claimant's attorney had filed a hearing request that the carrier had paid all the medical bills, Judge Rossman concluded that the Board's finding that the claimant's attorney was instrumental in obtaining compensation for the claimant without a hearing was supported by substantial evidence.

Thus, the Allen holding is that the claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) when the carrier failed to timely respond to the claimant's request for payment of unpaid medical bills for a compensable condition, but ultimately paid those bills prior to hearing. However, the particular reasons for each judge's decision are quite different.

Judge Leeson concluded that ORS 656.386(1) is not applicable because "compensability of claimant's injuries was not at issue." Judge De Muniz disagreed with that reasoning, noting that ORS 656.386(1) is premised on prevailing from a "decision denying the claim for compensation" and that medical services are included within the definition of "compensation." Nevertheless, since a carrier's failure to respond is neither acceptance nor denial, Judge De Muniz determined that the carrier's inaction could not be construed as a denial.

The first issue we are faced with concerns the precedential value of the plurality opinion in SAIF v. Allen. Generally, a decision by an appellate court is considered stare decisis on the questions involved, even if it is pronounced by a divided court. See Runnells v. Leffel et al., 105 Or 346, 357 (1922). However, it is a well-settled principle of jurisprudence that, when the majority of judges sitting on a case reach a decision, but do not agree on the underlying reasoning, the plurality vote is of no precedential value. See Churchill v. Pearl River Basin Dev. Dist., 619 So2d 900, 904 (Miss 1993) (citing Lakewood v. Plain Dealer Publishing Co., 486 US 750 (1988)); Fogarty v. Department of Transportation, 504 NW2d 710, 711 (Mich App 1993) (no point of law is established by a court's decision when the majority reaches a decision but does not agree on the underlying rationale).[1]

This principle applies to an opinion offered by one member of a three-member panel, when one of the remaining two judges concurs in the result and the other dissents. Johnson v. Harris, 615 A2d 771, 777 n 3 (Pa Super 1992). In that situation, the "lead" and concurring opinions have value only as instruction, not controlling precedent. See Williamson v. Cox, 844 SW2d 95, 99 (Mo App SD 1992).

The Allen case represents just such a plurality decision. Inasmuch as there is no consensus regarding the specific rationale for the Allen holding, we conclude that neither the "lead" nor the concurring[2] opinion is of any precedential value. Johnson v. Harris, supra. After considering the instructive value of those opinions, Williamson v. Cox, supra, we conclude that we must reexamine the relevant Supreme Court decisions for further guidance in analyzing the application of ORS 656.386(1).

As set forth in Shoulders v. SAIF, supra, at page 611, there are three prerequisites for an attorney fee award under ORS 656.386(1). One, the claimant must initiate an appeal. Two, the appeal must be from an order or decision denying the claim for compensation. Three, the claimant must finally prevail on the issue of compensation.

Since the carrier in Shoulders had requested Board review of a referee's decision ordering the claim accepted, the Supreme Court held that ORS 656.386(1) was not applicable. Instead, the Court reasoned that ORS 656.382(2) applied because the claimant had successfully defended against reduction of compensation for two conditions found compensable by the referee. In doing so, the Court concluded that medical services are included within the definition of "compensation."

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[1] No Oregon court has considered this precise issue. However, addressing an analogous issue, the Oregon Supreme Court recently noted that an affirmance by an equally divided court is not entitled to precedential weight. Perez v. Bay Area Hospital, 315 Or 474, 478 n 5 (1993).

[2] Judge De Muniz' opinion is denominated a concurrence. However, because he disagreed with the "lead" opinion's rationale, it appears that his opinion is, at least in part, actually a special concurrence. See Internal Practices of the Court of Appeals of Oregon 20 (Revised 1991) ("A specially concurring opinion may be submitted by a participating judge if that judge disagrees with or would not rely on the reasoning of the lead opinion but desires to state other reasons for concurring in the result."). This distinction is critical because, if Judge De Muniz' opinion were a straight concurrence (in that he agreed with the result and reasoning of the "lead" opinion, but desired to state an additional reason for the result or to address an issue not discussed in the "lead" opinion, see id.), the plurality majority would have precedential weight. See Community Med. Services v. Local 2665, Etc., 437 A2d 23, 26 n 4 (Pa Super 1981).

In light of such reasoning, we do not interpret the Shoulders decision as support for a conclusion that ORS 656.386(1) is limited to appeals from orders or decisions where only the "compensability" of the claimant's injury is disputed. To the contrary, consistent with the statutory language, the operative phrase is the claimant finally prevailing "from an order or decision denying the claim for compensation." Shoulders v. SAIF, supra, at page 611 (Emphasis supplied).

Likewise, the holding of Short v. SAIF, supra, does not support such a restrictive interpretation of ORS 656.386(1). In Short, the Supreme Court determined that ORS 656.386(1) was not applicable where a carrier had requested Board review of a referee's compensability decision and the claimant had cross-requested review concerning the reopening date for temporary disability. The specific holding in Short is that, since the claimant did not appeal from a decision denying a claim for compensation, ORS 656.386(1) did not apply. However, in dicta, the Court further stated that, where 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 . . . "[3]

Although the Short Court cited Shoulders as support for its statement suggesting that ORS 656.386(1) is solely applicable to disputes regarding whether the claimant's condition was caused by a compensable injury (i.e., "compensability"), such a statement is not contained in the Shoulders opinion. Rather, the Shoulders Court's holding provides as follows:

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[3] The Short Court also cited Cavins v. SAIF, 272 Or 162 (1975), as support for its decision. Although Cavins arose under the former statutory scheme which provided for circuit court appeals of Board orders, the version of ORS 656.386(1) was essentially the same as the current statute. Cavins also supports a conclusion that ORS 656.386(1) applies to denied medical service claims.

In Cavins, the carrier had accepted the claimant's ankle injury, but had refused to pay for a subsequent surgery on the theory that "the necessity for the surgery was not caused by the compensable injury." After the claimant appealed a Board order affirming a hearing officer's decision upholding the denial, the circuit court overturned the surgery denial. However, the circuit court refused to award a carrier-paid attorney fee under ORS 656.386(1).

The Cavins Court reversed the Court of Appeals decision affirming the circuit court's refusal to apply ORS 656.386(1), reasoning that "[t]he legislature clearly intended that a workman whose claim is erroneously rejected and who is thereby forced to appeal should not be forced to bear the additional expense of employing an attorney to represent him." Cavins v. SAIF, supra, at page 164. In doing so, the Cavins Court rejected the carrier's contention that ORS 656.386(1) was inapplicable because the Board's order did not deny an "original claim." Reasoning that ORS 656.386(1) required only a "claim for compensation," the Court concluded that the claimant was entitled to a carrier-paid attorney fee for prevailing over the Board order denying the medical services claim.

In reaching its decision, the Cavins Court also addressed the carrier's argument that ORS 656.386(1) was not applicable to medical services claims. After discussing a Court of Appeals decision (Wait v. Montgomery Ward, Inc., 10 Or App 333 (1972)) which could have been interpreted as inconsistent with its holding, the Cavins Court clarified that "to the extent that Wait v. Montgomery Ward could be regarded as impliedly interpreting ORS 656.386 as excluding the recovery of attorney's fees for medical services, it is in error." Cavins v. SAIF, supra, at page 165, n. 4.

Here, as in Cavins, the insurer refused to pay for claimant's surgery, contending that the medical services were not appropriate. Inasmuch as medical services are included within the phrase "claim for compensation," ORS 656.386(1) is applicable.

The Short Court also cited Ohlig v. FMC Marine & Rail Equipment, 291 Or 586 (1981), as support for its decision. In making a distinction between several other decisions which did not grant an attorney fee award under ORS 656.386(1), the Ohlig Court admittedly draws upon the existence of a "causality" dispute regarding the claim as support for the claimant's entitlement to a carrier-paid attorney fee pursuant to the statute. Id., at page 593-94.

Notwithstanding such reasoning, we do not interpret the Ohlig Court's holding as a determination that a claimant would be precluded from obtaining a carrier-paid attorney fee under ORS 656.386(1) for prevailing against an order or decision denying a medical services claim based only on the propriety or necessity of the medical treatment. Neither the Ohlig nor the Cavins Courts were faced with that particular question. Moreover, the "three prerequisites" for an attorney fee award under ORS 656.386(1) as subsequently identified by the Court in Shoulders do not expressly limit such an award to only "causality" denied claims. Consequently, we decline to interpret the Short, Ohlig, and Cavins decisions in such a restrictive fashion. Were we to do so, we would be requiring the claimant to bear the additional expense of employing an attorney to represent her when her medical services claim has been erroneously rejected. As noted by the Cavins Court, such a policy would be inconsistent with the legislature's clear intention in enacting ORS 656.386(1).

> "We conclude that under both clauses [of ORS 656.386(1)] a claimant must initiate the review or appeal from an order or decision denying the claim. Claimant may not receive attorney fees under ORS 656.386(1) where, as in this case, the insurer seeks board review of a hearing officer's order that the claim be accepted." Shoulders v. SAIF, supra, at page 615.

Not only is the holding of Shoulders not restricted to "compensability" disputes, but the Shoulders rationale would support a conclusion that ORS 656.386(1) is applicable to rejected medical service claims. Specifically, relying on the statutory language in ORS 656.386(1), the Shoulders Court premised its analysis on the claimant initiating and prevailing from an order or decision denying "the claim for compensation." Since the Shoulders Court considered "medical services" to be "compensation" which necessarily follows from a compensability finding, it is reasonable to assume that prevailing against an order or decision denying a medical services claim would likewise entitle a claimant to an attorney fee award under ORS 656.386(1).

Finally, the Short Court neither expressly disavowed nor modified any portion of the Shoulders holding. To the contrary, as previously explained, the Short Court cited Shoulders as support for its decision.

In light of such circumstances, we interpret the holding of Short to be that ORS 656.386(1) is not applicable where a carrier requests Board review of a referee's decision concerning a denied claim. We further view the Short Court's suggestion that ORS 656.386(1) is limited to "compensability" disputes to be a reference to the fact that, in that particular case, the carrier's appeal of a referee's decision concerned the issue of "whether the claimant's condition was caused by an industrial injury." We do not consider the Short Court's statement to establish the proposition that a carrier-paid attorney fee under ORS 656.386(1) is only awardable in "compensability" disputes. Were we to do so, we would be reading the phrase "from an order or decision denying the claim for compensation" right out of the statute, an action which would also be inconsistent with the rationale expressed in Shoulders.

Inasmuch as we find the opinion of Judge De Muniz in Allen regarding an attorney fee under ORS 656.386(1) to be in accordance with the Shoulders and Short holdings, we shall apply that reasoning in analyzing claimant's entitlement to an attorney fee award. See also Judge Rossman's dissent in Allen. The critical inquiry is whether the insurer's conduct constitutes a decision denying claimant's claim for compensation.

Whether a claim has been accepted or denied is a factual determination to be made on a case by case basis. See e.g. SAIF v. Tull, 113 Or App 449, 454 (1992); Doris A. Pace, 45 Van Natta 432, 434 (1993). Unlike the situation presented in Allen, this record is not limited to mere silence on behalf of the insurer. Rather, the record contains evidence which establishes that the insurer was denying or rejecting claimant's medical services claim for the proposed surgery. That evidence is as follows.

Following claimant's hearing request, the insurer directed a letter to claimant's physician (with copies to claimant and her counsel) which notified the physician of its position that the proposed surgery would be excessive, inappropriate and ineffectual treatment. (Ex. 94-1). Based on such reasoning (which it asserted was consistent with the opinion of an examining physician), the insurer requested that claimant's physician withdraw the surgery request. In the event that the surgery request was not withdrawn, the insurer further advised the physician of its intention to seek Director review of the proposed medical treatment.

In issuing its notice of opposition to the surgery, the insurer stated that the "compensability" of the proposed treatment was not at issue. The insurer further noted that no denials had been or would be issued regarding the treatment pending the outcome of the Director's decision. At the hearing, the insurer did not dispute that the proposed surgery was causally related to claimant's compensable bilateral wrist condition. Instead, the insurer described the issue in the following manner: ". . . at the heart of the matter is whether or not the surgery is reasonable and necessary in this case." (Tr. 12). Asserting that authority to resolve such issues rested with the Director, the insurer argued that the Hearings Division and Board were without jurisdiction over the surgery dispute.

The insurer's response to claimant's attending physician's surgery request, as subsequently confirmed by the insurer's position at the hearing, persuades us that the insurer was refusing to accept claimant's surgery claim. Notwithstanding the insurer's notice that it had not and would not issue a

denial of the proposed treatment, its characterization of the dispute at the hearing as a "reasonable and necessary" issue constitutes a "decision denying the claim for compensation." Inasmuch as claimant has finally prevailed on Board review over that denied medical services claim, we hold that she is entitled to an attorney fee award under ORS 656.386(1) for her counsel's services at the hearing and on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review regarding the surgery claim is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

In light of our decision regarding claimant's entitlement to an attorney fee award under ORS 656.386(1), we shall reexamine our attorney fee award pursuant to ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation. Our $2,500 attorney fee award was granted based on a decision that claimant was not also entitled to an attorney fee award under ORS 656.386(1). Inasmuch as we have now concluded that claimant is entitled to a $3,000 attorney fee award pursuant to ORS 656.386(1), we conclude that her attorney fee award under ORS 656.382(1) should be modified.

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 concerning the insurer's unreasonable resistance to compensation is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved. As previously noted, we have also taken into consideration claimant's $3,000 attorney fee award under ORS 656.386(1).

Finally, not only is our analysis regarding claimant's entitlement to a carrier-paid attorney fee under ORS 656.386(1) in accordance with the reasoning and requirements set forth in Shoulders v. SAIF, supra, but this result is also consistent with the fundamental objectives of the Workers' Compensation Law.

Under ORS 656.012(2)(b), a primary objective of the Workers' Compensation Law is "[t]o provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." Another objective is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c). Our decision today accomplishes these fundamental goals in several ways.

Consistent with the principles enunciated by the Supreme Court, we have clarified under what circumstances an injured worker will receive a carrier-paid attorney fee. Since prior to issuance of the SAIF v. Allen decision such fees were uniformly awarded in rejected medical service claims, our conclusion will return the law in this area to the status quo. Thus, litigation will hopefully be reduced in that it will be unnecessary for claimants' attorneys to appeal otherwise unappealed decisions overturning rejected medical service claims in order to secure a carrier-paid attorney fee.

This clarification will also reduce uncertainties concerning whether injured workers' attorneys will receive compensation for their efforts. The end result will likely be that injured workers will obtain legal representation when they so choose and, in doing so, the receipt of benefits to those workers with compensable claims will be expedited.

The reduction of protracted litigation and the expeditious recovery of compensation to injured workers with compensable claims not only benefits the worker, but also is in the best interests of Oregon employers. The employer avoids the attendant litigation expenses which flow from a hearing and subsequent appeals, but also regains the services of a physically and mentally self-sufficient worker in an expeditious manner. Returning the injured worker to the work force as rapidly as possible is economically beneficial to the worker, as well as to the employer.

Accordingly, on reconsideration, as modified herein, we republish our March 7, 1994 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
JOANN KILMER, Claimant
WCB Case No. 93-01652
ORDER ON REVIEW
Bradley A. Peterson, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Westerband, Gunn and Haynes.

Claimant requests review of Referee T. Lavere Johnson's order which upheld the self-insured employer's denial of claimant's right knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has treated for right knee pain since August 1990. Her original diagnosis was tendinitis. (Ex. 1). In September 1993, claimant bruised her knees in a nonwork-related automobile accident.

On October 26, 1992, claimant was employed as a meter reader for the employer. Her work required that she walk on rough and uneven ground, and climb through a rail fence. While at work, she felt "knee pressure" while walking and later, after climbing through the fence, she stepped to the ground, heard a snap and felt intense pain.

The Referee concluded that claimant had failed to prove a causal relationship between her work incident and her disability and need for treatment for a meniscal tear. We disagree.

Dr. Sulkosky examined claimant on November 24, 1992. He suspected a lateral meniscal tear, and a December 1, 1992 MRI confirmed a complex diffuse tear of the lateral meniscus. (Ex. 6).

Arthroscopic surgery revealed several different types of tears. (Ex. 8-2). A radial tear appeared fairly acute, whereas other tears appeared chronic and degenerative. Id. Dr. Sulkosky opined that claimant had a preexisting degenerative area of the meniscus which claimant completed into a full tear with her work activities. (Ex. 7).

Accordingly, claimant's resultant knee condition is compensable if the October 26, 1992 injury is the major contributing cause of her disability and need for treatment. ORS 656.005(7)(a)(B); Tektronix Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993).

Dr. Sulkosky provides the only medical opinion in the record. In a letter to a claims processor, Dr. Sulkosky states that the reason claimant sought treatment was the "acute" radial tear. (Ex. 9). Later, in a letter to claimant, Dr. Sulkosky attempted to clarify the opinion he had provided to a claims processor by stating that he did not specifically state that claimant's employment was not the major contributing cause of claimant's right knee condition. (Ex. 14). Subsequently, Dr. Sulkosky agreed that, based on his surgical findings of an acute radial tear of the lateral meniscus, the work injury was the major contributing cause of claimant's need for treatment. (Ex. 15).

In light of the fact that Dr. Sulkosky offers the only opinion on causation, and because he performed claimant's surgery, we are persuaded by his opinion. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988); Somers v. SAIF, 77 Or App 259 (1986). Thus, the employer's denial is set aside.

In setting aside the denial, we note, but disagree with the dissent's contention that Dr. Sulkosky's opinion is not persuasive, because he offered inconsistent opinions and expressed doubt about the validity of his ultimate conclusion. First, we are satisfied with the doctor's explanation for what might appear from a cursory reading of his statements to be some inconsistency on his part. As for his declaration that "only God knows for sure," we believe that Dr. Sulkosky is correct. About these questions of causation, "only God knows for sure."

When Dr. Sulkosky's statements are read together, they reveal, in our view, a physician who is prepared to offer his professional opinion on medical causation in terms of the "medical probabilities," but who recognizes the fact that for determining any question of medical causation, the sciences have their limits and, thus, "only God knows for sure." In any event, the applicable standard claimant must satisfy is "medical probability." To prevail, it is not necessary that claimant prove causation to a spiritual or medical certainty. Dr. Sulkosky's opinion establishes causation to a reasonable medical probability.

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 review is $3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record, and claimant's appellant's brief and reply brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 14, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $3,000 to be paid by the self-insured employer.

Board Member Haynes dissenting:

Claimant has the burden of proving, by a preponderance of the evidence, that her work incident is the major contributing cause of her disability and need for treatment. ORS 656.266. I agree with the Referee that claimant has failed to meet that burden.

After claimant's arthroscopic surgery, Dr. Sulkosky stated that he had found a radial tear in claimant's knee that he felt was acute, and other degenerative type tears that were preexisting. Dr. Sulkosky stated "only God can tell for sure" when addressing the question concerning claimant's reason for seeking treatment. (Ex. 9).

When a claims processor requested clarification of Dr. Sulkosky's report, Dr. Sulkosky signed the name "God" Sulkosky on a statement that claimant's preexisting condition was the major contributing cause of claimant's need for treatment. (Ex. 11-1). On January 25, 1993, Dr. Sulkosky signed the same statement, again agreeing that claimant's preexisting condition was the major contributing cause. (Ex. 11-2).

On April 23, 1993, in a statement contradictory to those above, Dr. Sulkosky signed a letter, written by claimant's attorney, agreeing that claimant's work-related injury was the major contributing cause of her need for knee surgery. I find that such an opinion, completely lacking in reasoning, does not meet the requirement of proof by a preponderance of the evidence. Furthermore, the Board has previously held that an opinion which consists entirely of a letter to a doctor from the claimant's attorney, summarizing a conversation between the two individuals, is conclusory and does not carry persuasive force. See LaDonna F. Burk, 44 Van Natta 781 (1992); Cary J. Halback, 43 Van Natta 2327 (1991).

Because I do not agree with the majority's reliance on a contradictory and conclusory opinion in reaching their conclusion that claimant's work incident was the major contributing cause of her need for knee surgery, I dissent.

In the Matter of the Compensation of
RICKIE S. KROHNKE, Claimant
WCB Case No. 93-04481
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

On April 13, 1994, we reversed that portion of a Referee's order that directed the SAIF Corporation recalculated the rate of claimant's temporary disability benefits and awarded an "out-of-compensation" attorney fee payable from those increased benefits. Representing that the parties have resolved their dispute pursuant to a Claim Disposition Agreement (CDA), claimant seeks withdrawal of our order so that we may retain jurisdiction over this case.

In light of claimant's unrebutted representations, we withdraw our April 13, 1994 order. On approval of the parties' CDA, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA F. McWHIRTER, Claimant
WCB Case No. 93-04805
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes and Gunn.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of her occupational disease claim for a right elbow and forearm condition. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated July 22, 1993 is affirmed.

Board Member Gunn dissenting.

Because I would find that the right elbow and forearm condition is a compensable occupational disease, I dissent.

As the Referee found, claimant has worked several years as a secretary, with 80 to 90 percent of her duties involving typing and word processing. Although claimant used both hands in these tasks, she testified that she used her right hand more often because she is right handed. (Tr. 6). In August 1992, claimant noticed the onset of pain in her right hand and arm, which was more severe at work.

Claimant saw orthopedist Dr. Ellison, who diagnosed extensor tendinitis of the right elbow and opined that "work activities are at least contributing to the problem." (Ex. 3-5). After claimant filed a claim for the condition, SAIF referred her to hand surgeon Dr. Button, who agreed with Dr. Ellison's diagnosis. However, Dr. Button "consider[ed] it doubtful that her work injury and/or exposure were the major contributing factors relative to the development of this form of extensor tendonitis/tennis elbow." While noting that this condition is sometimes attributed to prolonged typing and data entry, Dr. Button was doubtful that claimant's two-handed job duties could have caused only right-handed symptoms. The absence of left-handed symptoms prompted him to suggest that "activities of daily living and other pursuits" were more likely causes. (Ex. 6-3). SAIF subsequently denied the claim.

In May 1993 Dr. Ellison wrote: I believe it is medically probable that [claimant's] extensor tendinitis is secondary to her work activities. I have no idea why one arm is involved and not the other." (Ex. 10). Then, in June 1993, Dr. Ellison wrote that he agreed with Dr. Button's findings. (Ex. 8).

The Referee and, I assume, the majority found Dr. Button's opinion most persuasive, and discounted Dr. Ellison's opinion. Upon closer examination, however, I believe Dr. Ellison's opinion is better reasoned. Dr. Button's doubt concerning a work connection rests entirely on the absence of left-handed symptoms. But claimant is right-handed and testified that she used her right hand more often at work. Moreover, although Dr. Button suggests non-occupational reasons for claimant's condition, such as hobbies, gardening or "activities of daily living," there is no evidence in the record that claimant's off-work activities rose to the same level of frequency or intensity as her full-time, repetitive work activities. In addition, Dr. Button expressly rejected off-work sports activities as a factor, given claimant's sedentary lifestyle.

Given the absence of any other cause for claimant's condition, and the recognition that claimant's condition can be caused by the work activities she has been performing for several years, I cannot affirm the Referee's reliance on Dr. Button's opinion. Further, although Dr. Ellison concurred with Dr. Button's findings, that concurrence is unexplained. It is apparent that Dr. Ellison also could not explain the one-sided nature of claimant's symptoms. Insofar as that factor motivated his concurrence, I would not rely on that concurrence, but would rely, instead, on his narrative opinions attributing claimant's condition to her work activities.

For these reasons, I cannot join in the majority's affirmance of the Referee's order, and must respectfully dissent.

April 28, 1994 Cite as 46 Van Natta 832 (1994)

In the Matter of the Compensation of
ROBERT R. MUSIC, Claimant
WCB Case No. 93-04839
CORRECTED ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

On April 22, 1994, we issued an Order on Review which set aside the SAIF Corporation's denial of claimant's occupational disease claim for a right knee condition. It has come to our attention that our order contained a clerical error. Specifically, in the second sentence of the "Order" portion of our decision, we erroneously stated that the Referee's order had set aside SAIF's denial insofar as it pertained to claimant's right knee. In actuality, the Referee had upheld SAIF's denial in its entirety.

In the interests of correcting this oversight, we replace the "Order" portion of our prior decision with the following paragraph.

"ORDER

The Referee's order dated August 5, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the SAIF Corporation's April 7, 1993 denial with respect to the right knee is reversed. The SAIF Corporation's denial of claimant's occupational disease claim for his right knee is set aside, and the claim is remanded to SAIF for processing in accordance with law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the SAIF Corporation."

Accordingly, we withdraw our April 22, 1994 order. As clarified herein, we republish our April 22, 1994 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
KATHLEEN A. ROBINSON, Claimant
WCB Case No. 93-02515
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Mills' order that upheld the self-insured employer's denial of claimant's surgery and related treatment for an L5-S1 herniated disc. On review, the issue is compensability.

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

The issue presented by this case is whether claimant's herniated disc, which occurred during a medical examination performed on the employer's behalf, was a compensable consequence of claimant's compensable back injury.

On review, claimant argues that her disc herniation is compensable because the examining physician was a "contracted agent" within the meaning of ORS 656.018(3). She also presents arguments concerning an extended course and scope of employment, as well as statutory immunities.

We need not, and do not, address such issues because claimant also concedes that, under ORS 656.005(7)(a)(A), she must prove that her compensable back injury was the major contributing cause of her herniated disc. The medical evidence establishes that the major contributing cause of claimant's need for surgery was the new injury that she sustained during the medical examination, or some combination of that injury with a preexisting degenerative disc condition. On this record, we agree with the Referee that claimant has failed to establish that her need for disc surgery and related treatment was compensably related to her compensable back injury. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992).

ORDER

The Referee's order dated June 24, 1993 is affirmed.

In the Matter of the Compensation of
WILLIAM W. ROWLAND, Claimant
WCB Case No. 93-00497
ORDER ON REVIEW
Becker, Hunt & Hess, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Hazelett's order that upheld the self-insured employer's denial of claimant's left elbow injury claim. On review, the issue is course and scope of employment.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated June 22, 1993 is affirmed.

Board Member Gunn dissenting.

On September 4, 1992, claimant, a line truck driver for the employer, drove his regular route to Vancouver, B.C. Claimant habitually drives with his left arm resting on the ledge of the window of the driver's side door of his truck. Upon arrival in Vancouver, claimant went to his motel room and went to sleep. He awoke at about 3:30 a.m. on September 5, 1992 unable to move his wrist and hand. Claimant also had numbness of the left arm. These symptoms did not improve and claimant sought treatment at a hospital emergency room. The emergency room physician diagnosed radial nerve palsy.

Claimant subsequently returned to Portland and received medical treatment. Claimant's treating physician, Dr. Browning, diagnosed "peripheral radial and ulnar nerve palsies (compression neuropathy)."

The Referee and the majority rely on the opinion of examining physician, Dr. Button, rather than the opinion of Dr. Browning, the attending physician. Dr. Button, like Dr. Browning, diagnosed acute left radial and ulnar nerve compression syndrome. In reaching his conclusion that claimant's compression neuropathy was not work-related, Button posited that claimant's condition arose during sleep and was caused by alcohol use which resulted in an unusually heavy sleep on the left side. As Button explained, in this anesthetized state, the normal mechanism which causes people to turn during the night to relieve pressure does not exist and nerve damage due to excessive and prolonged pressure can occur. The only problem with this theory is that there is absolutely no evidence that claimant used any alcohol on September 4, 1992. In fact, the only evidence in the record on this subject is that claimant did not use any alcohol on the date in question. Thus, I would not rely on Dr. Button's opinion which amounts to mere conjecture concerning the cause of the nerve damage.

Dr. Browning's opinion, on the other hand, is not based on conjecture. Browning has opined that the protracted elbow flexion and pressure of the upper arm against the sharp edge of the window pane during the five hour long haul trip to Vancouver combined to produce the acute sensorimotor radial and ulnar neuropathy. As the Referee noted, Dr. Browning believed that claimant had had some previous symptoms of numbness before the September 4, 1992 incident. I do not find that this faulty belief detracts from the persuasiveness of Dr. Browning's opinion. In this regard, Dr. Browning did not base her opinion in large part on the history of numbness. Rather, Dr. Browning relied on claimant's accurate history of protracted flexion of the elbow combined with hard point pressure on the underside of the upper arm. Dr. Browning believed that this history (which is accurate) provided a reasonable medical explanation for the acute radial and ulnar neuropathy of claimant's left arm.

For the reasons set out above, I would rely on Dr. Browning's persuasive and well reasoned opinion to find the claim compensable. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
DIANA A. TRAVER, Claimant
WCB Case No. C4-00553
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewed by Board Member Neidig and Gunn.

On March 2, 1994, 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 March 15, 1994, the insurer submitted a Motion to Withdraw the CDA. The insurer's letter stated that the CDA was negotiated a year ago for a sum of $7,500, but was not submitted until after claimant's aggravation claim was found, by a Referee, to be not compensable. The insurer contends that claimant initially rejected the CDA and made a counter-offer, which had the legal effect of voiding the original offer. On March 17, 1994, we requested that the parties submit their respective positions concerning the proposed withdrawal of the CDA.

Prior to the Board's March 17, 1994 letter, we had also requested an addendum pursuant to OAR 438-09-020(2), noting that the agreement contained the following language:

> "[t]he accepted conditions which are the subject of this disposition are all compensable conditions arising out of the injurious exposure . . . and including the following: right forearm electrical burn. Such conditions may be limited by other proceedings on this claim. This disposition does not limit reasonable and necessary medical treatment related to such compensable conditions attributable to this claim." (Emphasis added).

Because we have previously held that a CDA can not be approved if it contains the abovementioned language, we requested that the parties clarify or remove the language. See Walter E. Fraidenburg, 46 Van Natta 116 (1994).

We have now received written responses from the parties concerning the withdrawal of the CDA. The parties do not agree on the disposition of the CDA. However, because we have not received the requested addendum, we need not address the merits of the parties' contentions.

We have previously held that the rules provide that a proposed claim disposition agreement must identify the accepted conditions that are the subject of the disposition. OAR 436-60-145(4)(a). See Karen J. Vega, 43 Van Natta 176 (1991). Here, the language of the proposed CDA suggests that additional conditions may have been accepted, but only one condition, right forearm electrical burn, is identified.

Furthermore, CDA's may dispose of only accepted conditions. See Frederick M. Peterson, 43 Van Natta 1069 (1991). Thus, the language stating that the accepted "conditions may be limited by other proceedings" could be construed to refer to a denial. Walter E. Fraidenburg, supra. Accordingly, although claimant contends that such language does not refer to a denied condition, pursuant to prior Board cases, a CDA containing such language cannot be approved.

Finally, the third sentence referring to "reasonable and necessary" medical services could be interpreted to limit a claimant's right to medical services. See Kenneth D. McDonald, 42 Van Natta 2307 (1990). Under the circumstances described above, because the parties have not submitted an addendum clarifying or eliminating the specified language, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2)(b); Walter E. Fraidenburg, supra. 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 shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed dispositions. 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.

In the Matter of the Compensation of
DAVID J. BUNK, Claimant
WCB Case Nos. 92-03345 & 92-02314
ORDER DENYING RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On January 26, 1994, we issued an Order on Review that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left leg from 4 percent (6 degrees), as granted by an Order on Reconsideration and affirmed by the Referee's order, to 26 percent (39 degrees); (2) increased claimant's unscheduled permanent disability award for a low back condition from 10 percent (32 degrees), as granted by the Referee's order, to 24 percent (76.8 degrees); and (3) affirmed those portions of the Referee's order which declined to assess penalties pursuant to ORS 656.268(4)(g) and award attorney fees under ORS 656.382(1).

On February 16, 1994, claimant petitioned the Court of Appeals for judicial review of our order. We have now received claimant's motion for reconsideration of our January 26, 1994 order.

Inasmuch as claimant has petitioned the court for judicial review of our order and since the 30-day period within which to withdraw and reconsider our order has expired, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1); SAIF v. Fisher, 100 Or App 288 (1990). 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 concluding that claimant was not entitled to a penalty under ORS 656.268(4)(g), we cited Vena K. Mast, 46 Van Natta 34 (1994), for the proposition that the Department must award the requisite increase in permanent disability for a penalty to be assessed under the statute. Noting that we have subsequently disavowed a portion of our Mast holding and have determined that we are also authorized to assess a penalty under ORS 656.268(4)(g), claimant seeks reconsideration of our decision and imposition of a penalty pursuant to the statute. In support of this motion, claimant relies on our recent decision in Steven L. Cline, 46 Van Natta 512 (1994). Inasmuch as we find this case to be distinguishable from Cline, we decline claimant's request for reconsideration.

In Mast, we held that, where, upon reconsideration, the Department increases permanent disability awarded by Notice of Closure to a level qualifying for assessment of a penalty under ORS 656.268(4)(g) (i.e., 25 percent or more increase with a 20 percent minimum award), but the referee or the Board subsequently reduces that award below the level qualifying for the penalty, the referee or the Board is authorized to reverse or reduce the penalty.

In Cline, we reasoned that ORS 656.268(4)(g) authorizes a penalty if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. If both conditions are met, but a penalty was not assessed by the Department, we concluded in Cline that the referee or the Board may assess the penalty. Consequently, in Cline, we disavowed Mast to the extent that Mast held that a referee or the Board was not authorized to assess a penalty under ORS 656.268(4)(g), even if the two requisite conditions were satisfied.

Here, our decision in Cline does not warrant the imposition of a penalty under ORS 656.268(4)(g). The insurer's August 7, 1991 Notice of Closure awarded 7 percent unscheduled permanent disability. The February 12, 1992 Order on Reconsideration reduced the unscheduled award to zero and awarded 4 percent scheduled permanent disability for the left leg (knee). The Referee's order, as well as our subsequent decision, found claimant to be at least 20 percent disabled and increased claimant's permanent disability award by at least 25 percent. Nevertheless, upon reconsideration, the Department did not find claimant to be at least 20 percent permanently disabled, and did not increase his award by 25 percent or more. Inasmuch as the two statutory prerequisites of ORS 656.268(4)(g) have not been satisfied, Cline does not support claimant's penalty request.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ERNIE L. CLONTZ, SR., Claimant
WCB Case No. 93-01444
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Baker's order that set aside the insurer'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

We adopt the Referee's Opinion and Conclusions, with the following supplementation.

Based on the medical evidence, it appears that claimant's theory is that his low back condition was caused directly by a work-related fall that occurred on November 14, 1989.[1] To prevail on that theory, claimant must establish that the fall was a material contributing cause of his disability or need for medical treatment. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991). For the following reasons, we conclude that claimant has met that burden.

On November 14, 1989, claimant fell from a ladder while he was at work, landing on his right foot and low back. As a result of the fall, claimant sustained a severe compound fracture of his right ankle. The right ankle was debrided, and thereafter surgically reduced. Claimant treated for the right ankle for one year. The insurer accepted a right ankle claim. The claim was closed by Determination Order on January 18, 1991, with an award of permanent partial disability.

Dr. Fredstrom, claimant's treating family physician, examined claimant several times between 1990 and 1992. (See Exs. 13, 14-1, 19, 27). Dr. Fredstrom performed an ICC physical in August 1990. (See Exs. 25, 27-4). At that time, Dr. Fredstrom did not note an ongoing back problem. (Id.)

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[1] In his brief, claimant asserts that Drs. Johnson and Fredstrom opined that his low back problems were causally related to his 1989 ankle injury. We conclude that claimant has misread the medical evidence. Dr. Fredstrom concluded that claimant's condition was causally related to his work accident, not the work injury. (See Ex. 25). Dr. Johnson's opinion stated that claimant

> "did fine and was very active until an injury where he sustained a blow to his lumbosacral spine. He has had progressive pain since and his pain in his back and legs was evaluated by myself in the office. He underwent a spinal decompression and fusion for the above-mentioned complains, and I think at this point in time it's medically probable that this was the major contributing cause of his injury, and I don't see that there is any other contributing cause of significance." (Ex. 29).

We construe Dr. Johnson's opinion to mean that the major contributing cause of claimant's low back condition was his November 1989 work accident. For these reasons, we understand claimant to be arguing that his condition was a direct result of the 1989 accident.

Claimant first complained to Dr. Fredstrom of low back pain in November 1991. (See Exs. 25, 27-5). At that time, claimant told Fredstrom that he had had intermittent low back pain since his 1989 work injury. (Ex. 27-5). Dr. Fredstrom treated claimant conservatively. (See id.)

Claimant returned to Dr. Fredstrom in September 1992, with complaints of ongoing low back aching and tenderness, and numbness, tightness and cramping in his buttocks and legs. (Exs. 13, 25, 27-6). Claimant told Dr. Fredstrom that he had had those symptoms for the past year and a half. (Ex. 13, 27-6). After a course of conservative treatment (Ex. 14-1), Dr. Fredstrom referred claimant to Dr. Johnson, orthopedic surgeon. Dr. Johnson obtained a CT scan that revealed severe stenosis at L4-5. (Exs. 15-2, 17). Thereafter, he performed an L4-S1 TSRH instrumentation, L4-S1 fusion and decompression L4-5, dual repair. (Exs. 25, 20).

Dr. Fredstrom concluded that "it does appear that significant back problem [sic] originated from the fall of 11/14/89." (Ex. 25). Likewise, Dr. Johnson concluded that, although some of claimant's spinal changes were degenerative (Ex. 30), it was medically probable that the major contributing cause of claimant's low back condition was his November 1989 accident. (Ex. 29; see Ex. 30).[2] In reaching that conclusion, Johnson considered significant claimant's history of being "fine" and "very active" before the November 1989 injury, and the fact that claimant sustained a blow to his lumbosacral spine during the fall. (See Exs. 29, 30).

Dr. Rich, neurologist, performed a records review on the insurer's behalf. He concluded:

> "I believe it is possible that [claimant] injured his low back when he fell from the ladder in November 1989. Apparently this was not much of a problem clinically because there is no mention of back pain or sacral pain in the initial emergency room or subsequent orthopedic reports. It would appear, upon review of the records and the nature of the abnormality present in this gentleman's low back, that the etiology is degenerative disease and there is no good reason to suspect any major traumatic component." (Ex. 22-2).

Dr. Wilson, neurologist, and Dr. Neufeld, orthopedist, examined claimant on the insurer's behalf. They reported that, although claimant said that he had hurt his lower back and coccyx during the November 1989 fall, he did not seek treatment for that condition until September 1992, several months after he had developed intermittent numbness from his waist down. (Ex. 26-1). They concluded that claimant did not significantly injure his back during the November 1989 injury. (Id. at 3). Rather, they believed that claimant had a "naturally-occurring degenerative disc disease of the lumbar spine that resulted in the lumbar canal stenosis at the L4-5 level[.]" (Id.)

When the medical evidence is divided, we tend to give greater weight to the opinions of the claimant's treating physician(s), absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

We find no persuasive reason not to defer to the opinions of Drs. Fredstrom and Johnson, claimant's treating physician and orthopedic surgeon. Both physicians examined claimant several times, and based their opinions on an accurate history of claimant's November 1989 accident and his subsequent clinical course. Viewing their reports as a whole, we are persuaded that Drs. Fredstrom's and Johnson's reports establish that claimant's November 1989 work accident was at least a material contributing cause of his low back condition.

The insurer argues that, because Dr. Fredstrom did not note an ongoing back problem during claimant's August 1990 physical, claimant has failed to establish that his back problem was directly caused by his November 1989 accident. We disagree.

In November 1991, claimant complained to Dr. Fredstrom of intermittent back pain. (Ex. 27-5). In September 1992, he complained to Dr. Fredstrom of ongoing low back aching and tenderness, as well as numbness, tightness and cramping in his buttocks and legs for the past year and a half. (Exs. 13, 27-

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[2] See note 1, supra.

6). Because claimant initially complained of intermittent back pain, and because claimant's increased symptoms did not appear until sometime around March 1991, we are not persuaded that claimant's failure to report back symptoms in August 1990 is significant.

The insurer also argues that, because Dr. Johnson acknowledged that some of claimant's low back condition was attributable to degenerative changes (see Ex. 30), we should discount Dr. Johnson's opinion. We disagree.

Dr. Johnson reasoned that the major contributing cause of claimant's condition was his November 1989 accident. (Ex. 29) It follows that, in Johnson's view, the degenerative changes were, at most, a material contributing cause of claimant's low back condition. Claimant need not disprove the existence of other material causes of his condition. See ORS 656.266. Rather, he need only prove that his fall was a material cause of his low back condition. ORS 656.005(7)(a); Mark N. Wiedle, supra. Because we are persuaded by Dr. Johnson's causation analysis, we reject the insurer's degenerative changes argument.[3]

We find compelling reasons to discount the reports of Dr. Rich and Drs. Wilson and Neufeld. First, their reports are based on an inaccurate history, in that they state that claimant first sought medical treatment for his back in September 1992. The record belies that history. (See Ex. 27-5).

For two additional reasons, we find the report of Dr. Rich particularly unpersuasive. First, Dr. Rich concludes that claimant's back pain was "not much of a problem clinically because there is no mention of back pain or sacral pain in the initial emergency room or subsequent orthopedic reports." (Ex. 22-2). That analysis is faulty, because it fails to take into account that, at the time of the November 1992 incident, claimant's severely fractured ankle was the major focus of his medical treatment. (See Ex. 25).

Second, Dr. Rich stated that it was "possible that [claimant] injured his low back when he fell from the ladder in November 1989." (Ex. 22-2). However, Dr. Rich then said that, based on his review of the records and the nature of the claimant's condition, there was "no good reason to suspect" that claimant's back condition was compensably related to the November 1989 fall. (Id.) Because those conclusions are logically inconsistent, we discount them.

In sum, for the foregoing reasons, we conclude that claimant has established the compensability of his low back condition. Accordingly, we affirm the Referee's opinion and order.

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

ORDER

The Referee's order dated September 15, 1993 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the insurer.

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[3] None of the medical evidence specifically addressed claimant's condition in terms of ORS 656.005(7)(a)(B), which states that, if a compensable injury combines with a preexisting condition, the resultant condition is compensable if the compensable injury is and remains the major contributing cause of the resultant condition. Drs. Wilson's and Neufeld's report concluded that claimant had a "naturally-occurring degenerative disc disease of the lumbar spine that resulted in the lumbar canal stenosis at the L4-5 level[.]" (Ex. 26-3). Neither that report, nor any other evidence, addressed whether claimant's degenerative spinal condition had preexisted his November 1989 work accident. Therefore, ORS 656.005(7)(a)(B) is not implicated.

In its reply brief, the insurer argues that claimant's condition is not compensable as a consequence of his November 1989 ankle injury. See ORS 656.005(7)(a)(A). Because no medical evidence characterized claimant's current condition as a consequence of his 1989 ankle injury, ORS 656.005(7)(a)(A) is not applicable.

In the Matter of the Compensation of
MICHAEL J. HOOEY, Claimant
WCB Case No. 92-08085
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Mongrain's order which affirmed an Order on Reconsideration award of 42 percent (56.7 degrees) scheduled permanent disability for loss of use or function of the left foot (ankle). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable left foot injury, which resulted in a talus fracture and partial rupture of the Achilles tendon. Claimant is unable to walk or stand for more than two hours in an eight hour period without experiencing excruciating pain. The Referee found that claimant had sustained a severe injury in terms of residual weight-bearing impairment. However, the Referee determined that there was no medical opinion that could verify claimant's inability to walk or stand for more than two hours in an eight hour period. The Referee, therefore, concluded that claimant was not entitled to additional impairment under OAR 436-35-200(4).

An award of 15 percent impairment under OAR 436-35-200(4) is appropriate where the objective medical evidence indicates that a severe injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period. Here, Dr. Versteeg, medical arbiter, could not objectively confirm claimant's estimation that he could stand for one hour and walk for 30-40 minutes. Dr. Versteeg, however, concluded that claimant was moderately restricted from prolonged walking and standing. At the time of claim closure, Dr. Jones, claimant's treating physician, reported that despite physical therapy and strengthening exercises claimant had been unable to extend his ability to stay on his feet beyond an hour or two. (Exs. 4, 9). These doctors conclusions were based on their respective evaluation of claimant's description of his limitation. This is sufficient to satisfy the "objective findings" requirement. Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992); John G. Williamson, 45 Van Natta 1156 (1993).

This 15 percent impairment rating is combined with claimant's other scheduled impairment findings (42 percent) in the foot for a total value of 51 percent impairment. OAR 436-35-200(4). Accordingly, we modify claimant's scheduled permanent disability from the Order on Reconsideration's 42 percent award to 51 percent scheduled permanent disability for the left foot.

ORDER

The Referee's order dated June 25, 1993 is modified. In addition to the Order on Reconsideration award of 42 percent (56.7 degrees), claimant is awarded 9 percent (12.15 degrees) scheduled permanent disability, for a total award to date of 51 percent (68.85 degrees) scheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

In the Matter of the Compensation of
CAROLE R. JEFFRIES, Claimant
WCB Case Nos. 93-02081 & 93-01886
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Spangler's order which: (1) decreased claimant's unscheduled permanent disability award for a compensable March 1991 low back condition from 21 percent (67.2 degrees), as awarded by a February 1, 1993 Order on Reconsideration, to 18 percent (57.6 degrees); (2) increased claimant's unscheduled permanent disability award for a compensable October 1991 cervical and low back condition from 6 percent (19.2 degrees), as awarded by a February 3, 1993 Order on Reconsideration, to 11 percent (35.2 degrees); (3) directed the SAIF Corporation to pay a 10 percent approved fee awarded by the February 1, 1993 Order on Reconsideration; and (4) declined to assess a penalty and attorney fee for an allegedly unreasonable resistance to the payment of compensation. In her brief, claimant contends that she is entitled to an award of scheduled permanent disability for loss of use or function of her left leg. In its brief, SAIF seeks a reduction of the permanent disability award under the March 1991 claim. On review, the issues are extent of unscheduled and scheduled permanent disability, penalty, 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

Permanent Disability

Claimant's compensable conditions became medically stationary on June 9, 1992. Claimant's March 13, 1991 low back injury claim was closed by an August 11, 1992 Notice of Closure without an award of permanent disability. Her October 1, 1991 cervicothoracic and low back injury claim was also closed by an August 11, 1992 Notice of Closure with an award of 29 percent unscheduled permanent disability. Accordingly, we apply the standards effective March 13, 1992, as promulgated in WCD Admin. Order 6-1992. OAR 436-35-003(2); (WCD Admin. Order 93-056).

March 13, 1991 Injury Claim (7107266E)

The Referee discounted the opinions of claimant's treating physician, Dr. Danner, and attending chiropractor, Dr. Freeman, because their impairment findings were based on examinations performed nearly four months before claimant became medically stationary. Rather, the Referee relied on the June 24, 1992 physical capacities evaluation (PCE), with which claimant's treating physician concurred. [Exs. 24, 25] Based on the PCE findings, the Referee computed claimant's impairment due to the March 1991 injury as 6 percent.

Claimant relies on the report of Dr. Danner and Dr. Freeman dated October 12, 1992 (Ex. 27), which was based on a February 20, 1992 examination by Dr. Freeman, D.C. (Ex. 32A).

Impairment must be measured based on claimant's condition at the time his condition is medically stationary. See Ronald E. Ingram, 44 Van Natta 313, 314 (1992); Darlene J. Byrd, 42 Van Natta 1029 (1990) (we rely on range of motion findings which are most recent and nearest the medically stationary date). Because claimant was not medically stationary at the time of Dr. Freeman's February 1992 examination, the October 1992 report is not persuasive evidence concerning the extent of claimant's permanent disability. Joslin A. McIntosh, 45 Van Natta 1655 (1993). Accordingly, we do not rely on the October 1992 report.

Dr. Hunt performed an independent medical examination on June 9, 1992. Dr. Danner concurred with Dr. Hunt that claimant's condition was medically stationary, and that she could return to work in the light to medium category with restrictions on repetitive bending, lifting, twisting, standing, etc. (Exs. 21, 25). Dr. Danner did not specifically concur with Dr. Hunt's range of motion findings. However, Dr. Danner concurred with the PCE. (Ex. 24). Impairment findings made by a consulting

physician or other medical provider at the time of claim closure may be used to determine impairment only if the attending physician concurs with the findings. OAR 436-35-007(8); Kathy Bott, 44 Van Natta 2366 (1992). We, therefore, rely on the June 24, 1992 PCE and on Dr. Hunt's June 1992 report, to the extent of Dr. Danner's concurrence with that report.

Impairment

We agree with the Referee that claimant's lumbar ranges of motion for flexion and extension are unreliable and, therefore, that claimant has failed to establish measurable impairment. See Kristy R. Schultz, 46 Van Natta 294 (1994); Juel L. Fadness, 43 Van Natta 520 (1991). However, the Referee incorrectly calculated claimant's lumbar ranges of motion for retained lateral flexion.

The physical therapist reported that claimant's lumbar flexion and extension range of motion findings were inconsistent and thus invalid, but otherwise found, based on use of the inclinometer, that claimant had retained right lateral flexion of 17 degrees for 1.6 percent impairment, and retained left lateral flexion of 15 degrees for 2 percent impairment. OAR 436-35-360(21).

For a total impairment value due to loss of motion as measured by inclinometer, these values are added for a total of 3.6 percent impairment in the low back. These values are then rounded to the nearest whole number, 4 percent. OAR 436-35-360(22) and 436-35-007(13). Dr. Danner apportioned claimant's impairment equally between her two injuries. Accordingly, two percent impairment is due to the March 1991 injury.

Claimant contends that she is entitled to a value of five percent for chronic condition impairment of the low back. Claimant must show, based on medical evidence, at least a partial loss of ability to repetitively use her low back. OAR 436-35-320(5); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Dr. Hunt advised that claimant could return to work with permanent restrictions. He opined that claimant had 5 percent impairment for inability to do repetitive bending, lifting, twisting, standing, etc. Dr. Danner concurred that claimant had some permanent impairment and that she could return to work with permanent restrictions in repetitive bending, twisting, lifting, etc. Based on the doctors' permanent restrictions on repetitive bending, twisting and lifting, we conclude that claimant is unable to repetitively use her low back due to a chronic and permanent condition.

Because claimant has less than 5 percent unscheduled rateable impairment in the low back, she is entitled to 5 percent unscheduled impairment in lieu of all other unscheduled impairment in the low back. OAR 436-35-320(5)(b).

Claimant also seeks 7 percent scheduled disability for loss of use or function of the left leg based on L5 nerve damage with resultant loss of strength. Claimant relies on medical evidence which we have already found not persuasive because it was based on examinations prior to claimant's medically stationary status. Moreover, although not specifically concurred in by Dr. Danner, Dr. Hunt found, at the time claimant became medically stationary, that claimant had 5/5 strength. We conclude that claimant has failed to prove loss of strength in her left leg attributable to a peripheral nerve injury, loss of muscle, or disruption of the musculotendonous unit. OAR 436-35-230(8).

Age

The parties do not dispute the value of one (1) for age.

Education

The parties do not dispute the value of one (1) for claimant's formal education and the value of three (3) for her skills based on a SVP of four (4).

Adaptability

The adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity (RFC) at the time of determination. OAR 436-35-310(1).

Claimant's job title as a CNA is classified as requiring medium strength. DOT #355.377-014. Claimant's maximum RFC is her remaining ability to perform work-related activities despite impairment. OAR 436-35-270(3)(d). Dr. Danner restricted claimant to work in the light to medium range. (Ex. 25). He also restricted claimant from repetitive bending and twisting, but did not describe the extent of these restrictions. Based on the PCE, however, claimant is only restricted from frequently reaching at arm's length. (Ex. 22). Inasmuch as claimant is not precluded from frequently performing at least two listed activities, claimant's adaptability is determined under OAR 436-35-310(3). OAR 436-35-270(3)(e). Thus, claimant's RFC is medium to light. Where claimant's prior strength is medium and her RFC is medium/light, her adaptability factor is 2. OAR 436-35-310(3).

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 (4) for education is (5). The product of that value and the value (2) for claimant's adaptability is (10). The sum of that product and the value (5) for claimant's impairment is (15). That value represents claimant's unscheduled disability for the March 1991 injury. OAR 436-35-280. Consequently, the Referee's award of 18 percent is reduced to 15 percent.

October 1, 1991 Injury Claim

We affirm the Referee's conclusion with the following modification. In awarding claimant 11 percent unscheduled permanent disability, the Referee apportioned 3 percent of the 6 percent total impairment of the lumbar condition to the October 1991 injury claim. As discussed above, we have found claimant's impairment as a result of loss of lumbar range of motion equaled 4 percent. Thus, claimant's impairment concerning the October 1991 claim is 2 percent. Accordingly, claimant's permanent disability for the October 1991 injury equals 10 percent. However, since claimant has failed to establish that she is entitled to a greater award of permanent disability than that awarded by the Referee, and SAIF has not cross-appealed or sought a reduction of the Referee's 11 percent permanent disability award, the Referee's award is affirmed.

Penalty and Attorney Fees

The Referee found that SAIF had lawfully stayed the payment of the permanent disability award under the February 1, 1993 Order on Reconsideration pursuant to ORS 656.313. The Referee, however, found that ORS 656.313 did not apply to the (10 percent) approved fee granted by the Order on Reconsideration because attorney fees are not compensation. Since the attorney fees were not compensation, the Referee determined that SAIF did not unreasonably refuse to pay the approved attorney fee. The Referee, therefore, concluded that claimant was not entitled to a penalty and penalty-related attorney fee.

Claimant contends that an attorney fee paid "out of compensation" retains its identity as compensation. As such, she is entitled to a penalty based on the approved attorney fee amount for unreasonable failure to pay the fee.

Claimant is correct that an "out-of-compensation" attorney fee is part of her compensation. Steiner v. E.I. Bartells Co., 114 Or App 22 (1992). Thus, SAIF is correct that as part of claimant's compensation, ORS 656.313 is applicable to stay the payment of the approved fee. It would be anomalous to stay the compensation on which the attorney fee is based, but not stay the attorney fee. In addition, OAR 438-15-082 ties the timely payment of an approved attorney fee with the payment of the compensation out of which the fee is to be paid. Since there has been no unreasonable refusal or delay in paying the approved fee, no penalty or penalty-related fee is warranted.

Claimant next contends that she is entitled to an approved attorney fee for the increased permanent disability awarded by the Referee. We agree.

The October 1991 injury claim was closed by Notice of Closure with an award of 29 percent (92.8 degrees) unscheduled permanent disability. The record does not establish whether SAIF paid the full award to claimant. The Order on Reconsideration reduced the award to 6 percent (19.2 degrees) unscheduled permanent disability. The Referee awarded 11 percent (35.2 degrees) unscheduled permanent disability. We have affirmed the Referee's award of 11 percent (35.2 degrees) unscheduled permanent disability.

In Jane A. Volk, 46 Van Natta 681 (1994), we found that claimant's counsel was instrumental in obtaining a "substantive increase" in the claimant's permanent disability award where the insurer's existing overpayment was reduced and the insurer's ability to offset its overpayment against future benefits was limited. Counsel was, therefore, entitled to an "out-of-compensation" attorney fee in the amount equal to the increase between the permanent disability awarded by the reconsideration order and the permanent disability ultimately awarded. We further held that, if the compensation had already been paid to the claimant, the attorney must first seek recovery of the fee directly from the claimant.

Here, claimant's permanent disability award, for the October 1991 injury claim, was increased by 5 percent unscheduled permanent disability (the difference between the 6 percent awarded by the Order on Reconsideration and the 11 percent awarded by the Referee). This increase reduced SAIF's overpayment (if any) and limited its ability to offset the overpayment against future awards. Since claimant's counsel has been instrumental in obtaining an increase in claimant's permanent disability, he is entitled to an approved attorney fee equal to 25 percent of the 5 percent increased compensation created by our order, not to exceed $3,800. This fee shall be recovered from claimant in the manner set forth in Jane A. Volk, supra.[1]

ORDER

The Referee's order dated June 8, 1993 is modified in part and affirmed in part. That portion which awarded 18 percent (57.6 degrees) unscheduled permanent disability for the March 13, 1991 low back injury (claim #7107266E) is modified to award 15 percent (48 degrees) unscheduled permanent disability. Claimant's counsel is allowed an "out-of-compensation" attorney fee payable from the 5 percent increased unscheduled permanent disability granted by the Referee under the October 1991 claim. That fee shall be recovered from claimant in the manner set forth in this order. The remainder of the order is affirmed.

[1] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Volk, Member Hall directs the parties to his dissenting opinion in that decision.

April 29, 1994 Cite as 46 Van Natta 844 (1994)

In the Matter of the Compensation of
RYAN F. JOHNSON, Claimant
WCB Case No. 93-02394
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of Referee Livesley's order which: (1) excluded the deposition of a consulting physician (Exhibit 17) and excluded a "post-reconsideration" report from the medical arbiter, which included the employer's letter to the medical arbiter (Exhibits 34 and 35); (2) affirmed a February 19, 1993 Order on Reconsideration awarding 63 percent (15.12 degrees) scheduled permanent disability bilaterally for loss of use of the left and right index fingers; (3) awarded a $2,250 assessed attorney fee pursuant to ORS 656.382(2) for prevailing over the employer's request for hearing; (4) awarded a 25 percent penalty pursuant to ORS 656.268(4)(g); (5) set aside its partial denial of claimant's current condition; (6) awarded a $1,500 assessed attorney fee pursuant to ORS 656.386(1) for prevailing over the employer's partial denial; and (7) awarded a $750 assessed attorney fee pursuant to ORS 656.382(1) for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are evidence, extent of scheduled permanent disability, propriety of the employer's denial, penalty and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant has Raynaud's Phenomenon, an ideopathic, underlying condition which results in vasospasms of the small blood vessels that temporarily reduce blood flow, causing pain and discoloration of the hands and fingers. The vasospasms and resulting symptoms are the only manifestations of the phenomenon. Ryan F. Johnson, 45 Van Natta 1129, 1130 (1993).

At the time the medical arbiter issued his February 8, 1993 report, requested testing had been performed, but the results were not yet available to the medical arbiter. Accordingly, the medical arbiter stated that he would finish his report when the information was available. However, the Department never sought or obtained a completed medical arbiter report.

CONCLUSIONS OF LAW AND OPINION

The employer's theory of the case is premised on the contention that claimant's compensable condition resolved without permanent impairment. Thus, it argues that any permanent impairment is due to claimant's underlying disease. The employer contends that the Board's order found claimant's symptoms complex compensable, but not the underlying disease. Consequently, the employer argues that the symptoms which the Board found to be the compensable occupational disease were not permanent.

Evidentiary Ruling

The Referee excluded Exhibit 17, Dr. Dordevich's deposition, on the ground that it was irrelevant because it pertained primarily to the causation issue which had already been litigated. (Tr. 2-3).

Subsequent to the Referee's order, in Frank H. Knott, 46 Van Natta 364 (1994), we determined that ORS 656.245(3)(b)(B) did not limit evidence concerning the causal relationship between the compensable injury and the permanent impairment. Thus, evidence from a nonattending physician can be considered to determine whether the claimant's permanent impairment is attributable to his compensable condition. In reaching this conclusion, we considered ORS 656.245(3)(b)(B) in conjunction with ORS 656.214(5) which provides that the "criteria for rating of [unscheduled] disability shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis added). Id.

Here, the criteria for rating of scheduled disability is similar: "the permanent loss of use or function of the injured member due to the industrial injury." ORS 656.214(2). (Emphasis added). Thus, as with permanent disability evaluations under ORS 656.214(5), we conclude that evidence from nonattending physicians concerning the causal relationship between claimant's compensable condition and the permanent impairment is likewise relevant to determining the extent of disability pursuant to ORS 656.214(2).

Dr. Dordevich's deposition does not make impairment findings, but it does discuss the nature and extent of claimant's symptoms, and the relationship between those symptoms and his compensable condition. Accordingly, his testimony is relevant to the extent of disability issue. Since Exhibit 17 is in the record, it will be admitted and considered on review.

The Referee also excluded Exhibit 34 (an April 6, 1993 letter from the employer's counsel to the medical arbiter) and Exhibit 35 (the medical arbiter's April 8, 1993 response) on the ground that the medical arbiter's response issued after the February 19, 1993 Order on Reconsideration.

Subsequent to the Referee's order, the Court of Appeals held that ORS 656.268(5) did not prevent a referee from considering evidence at hearing that could not have been submitted to the Director on reconsideration. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Based on Smith, we have held that medical reports, even though not considered on reconsideration pursuant to ORS 656.268(5), are admissible at hearing provided that no other statutory limitations on evidence are applicable. Gary C. Fischer, 46 Van Natta 60 (1994); Cynthia L. Luciani, 45 Van Natta 1734 (1993).

Here, although the medical arbiter initially rendered a report on February 8, 1993, he stated that he would finish the report as soon as testing information was available. However, prior to its February 19, 1993 reconsideration order, the Department did not request the medical arbiter to complete his report

or reschedule another arbiter examination. Inasmuch as the Medical Arbiter's April 8, 1993 report is based on medical evidence generated prior to the date of the reconsideration order and explains the test results, thereby "completing" his initial findings, we find that the document constitutes "findings of a medical arbiter" rather than "subsequent medical evidence" under ORS 656.268(7). See Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993) (ORS 656.268(7) prohibits admission of evidence developed after the medical arbiter's report, not the actual medical arbiter's report); Gary C. Fischer, supra; Lorenzo Orozco-Santoya, 46 Van Natta 150 (1994) (subsequent clarification of a medical arbiter's initial findings constituted "findings of a medical arbiter").

Accordingly, Exhibits 34 and 35 are relevant to claimant's permanent disability as of the date of the reconsideration order and should have been admitted at hearing. Because the exhibits are already in the record, they have been considered on appeal. See Herbert D. Rustrum, 37 Van Natta 1291 (1985).

Extent of Disability

The employer contends that the symptoms which the Board determined to be the compensable occupational disease are not permanent and since claimant has no permanent impairment due to his compensable condition, he is not entitled to an award of permanent disability. We disagree.

In our prior order, we found that claimant has Raynaud's Phenomenon, an ideopathic, underlying condition. We also found that, for purposes of establishing compensability under ORS 656.802, the symptoms of Raynaud's Phenomenon were the disease. We relied on Dr. Teal's opinion, that claimant's cold exposure at work was the major contributing cause of the Raynaud's symptoms, to find the claim compensable. Thus, although Raynaud's Phenomenon is only manifested through symptoms, any impairment caused by the symptoms is due to claimant's compensable occupational disease.

OAR 436-35-110(6)(d) provides for 63 percent impairment when "Raynaud's phenomenon occurs on exposure to temperature below 15 [degrees] Centigrade and is only partially controlled by medication."

Dr. Wasner, claimant's treating physician, opined that the temporary exacerbation caused by claimant's work exposure resolved without permanent impairment. (Ex. 25). However, after leaving his employment, claimant continued to experience episodes of symptoms with cold exposure or anxiety, which were short and intermittent. (Exs. 25, 32). As claimant's Raynaud's Phenomenon progresses, he becomes more and more sensitive to developing symptoms. (Ex. 17 pp. 15, 23, 27). Test results show that Raynaud's Phenomenon occurs on exposure to temperature below 15 degrees Centigrade. (Ex. 31). Dr. Hallin explained that it would require clinical frostbite with blistering to have permanent effects on the underlying Raynaud's Phenomenon to produce the results found on testing. He, therefore, opined that claimant's cold exposure at work did not influence the test results. (Ex. 35).

The medical evidence establishes that, although the particular symptoms due to claimant's work exposure have resolved, claimant suffers impairment due to his Raynaud's Phenomenon, which we have found compensable.

The employer next contends that claimant has not satisfied the requirement that his Raynaud's Phenomenon is only partially controlled by medication. Dr. Dordevich testified that Procardia is an effective medication to prevent Raynaud's Phenomenon. (Ex. 17-65). However, claimant told Dr. Hallin that he did not feel that Procardia made much of a difference in his symptoms. (Ex. 32). Based on claimant's testimony and on his recurrent symptoms, we find that claimant's Raynaud's Phenomenon is only partially controlled by medication. Accordingly, claimant has established that he is entitled to 63 percent permanent disability.

We adopt the Referee's conclusion regarding the assessed attorney fee award under ORS 656.382(2).

ORS 656.268(4) Penalty

Although the Order on Reconsideration found claimant to be 63 percent disabled, which was more than a 25 percent increase of the amount of compensation to be paid to claimant, the order failed

to award a penalty under ORS 656.268(4). The Referee, therefore, awarded a 25 percent penalty. We agree with the Referee's penalty assessment.

ORS 656.268(4) authorizes assessment of a penalty against an insurer or self-insured employer if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. Vena K. Mast, 46 Van Natta 34 (1994); Cynthia L. Luciana, 45 Van Natta 1734 (1993). If the statutory requirements are met, the claimant is automatically entitled to the penalty, without regard to whether the carrier's action was reasonable. Kevin Northcut, 45 Van Natta 173 (1993).

Here, we find that both conditions were satisfied. The employer's Notice of Closure awarded claimant no permanent disability for the Raynaud's Phenomenon. The Order on Reconsideration awarded claimant 63 percent scheduled disability for the left finger and 63 percent for the right finger, resulting in an increase of $9,223.20 in permanent disability benefits. Thus, upon reconsideration, claimant was found to be at least 20 percent permanently disabled, and the amount of claimant's permanent disability compensation was increased by more than 25 percent over the Notice of Closure award.[1] (See Exs. 26 and 33).

Therefore, ORS 656.268(4)(g) requires the assessment of a penalty. We have found no language in ORS 656.268(4)(g) which prohibits the Board or Hearings Division from assessing a penalty, if the aforementioned conditions have been met, nor is there any language which limits the penalty assessment authority to the Department. Rather, the statute is phrased broadly and does not specify that any particular body must assess the penalty; it merely requires that "a penalty shall be assessed." Steven L. Cline, 46 Van Natta 132, on recon 46 Van Natta 512 (1994). Accordingly, the Referee properly assessed a penalty under ORS 656.268(4)(g).

Partial Denial

We adopt the Referee's conclusion concerning the impropriety of the employer's denial.

ORS 656.386(1) Attorney Fee

On February 26, 1993, the employer requested a hearing regarding the February 19, 1993 Order on Reconsideration. The employer also issued, on April 29, 1993, a partial denial of claimant's current condition on the grounds that: (1) it considered the permanent disability awarded by the Order on Reconsideration to be a claim for compensation; and (2) claimant's current disability and symptoms were related to his underlying Raynaud's Phenomenon rather than the accepted symptoms of the Raynaud's Phenomenon. Claimant requested a hearing from the employer's denial.

The Referee set aside the employer's partial denial, as improper, on the ground that an Order on Reconsideration is not a claim. The Referee also awarded a $1,500 assessed attorney fee under ORS 656.386(1) for claimant's counsel services in prevailing against the denial.

We need not resolve the issue of whether the Order on Reconsideration represents a claim for compensation, because, even if it does not, claimant has finally prevailed against the employer's denial of claimant's current Raynaud's Phenomenon disability. Since the employer's April 1993 partial denial denied claimant's current disability and symptoms, it constitutes a denial of a claim for compensation. Because our prior order held that the employer is responsible for claimant's Raynaud's Phenomenom and not merely a temporary symptomatic worsening of that condition, claimant has likewise finally prevailed against the denial. Accordingly, an attorney fee award under ORS 656.386(1) is warranted. Based on the factors set forth in OAR 438-15-010(4), we find that the Referee's $1,500 assessed attorney fee award is reasonable.

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[1] Although required by the doctrine of stare decisis to follow the Board's holding in Mast, Member Gunn directs the parties to his dissenting opinion in that decision.

ORS 656.382(1) Penalty and Attorney Fee

The Referee found the partial denial unreasonable on the ground there was no legal basis for issuing the denial. We disagree.

The reasonableness of the employer's denial must be gauged upon the information available to the employer at the time of the denial. If the employer based its denial upon a legitimate doubt, the denial was not unreaonable. Brown v. Agronaut Insurance Co., 93 Or App 588 (1988).

At the time the employer issued its denial, it had, based on the prior Referee's order, accepted a temporary worsening of claimant Raynaud's Phenomenom. Also at that time, medical evidence indicated that the temporary worsening caused by claimant's work exposure had resolved. Our order holding the employer liable for claimant's Raynaud's Phenomenom issued subsequent to the employer's denial and to the hearing on that denial, but before the Referee's order. Based on the above, we find that the employer had a legitimate doubt as to its liability for claimant's current condition and disability. Accordingly, because the denial was not unreasonable, the Referee's penalty award is not warranted.

The Referee further found that the issuance of the partial denial constituted an unreasonable resistance to the payment of compensation because, if gone unappealed, the employer could have used the partial denial to refuse to pay the permanent disability awarded by the Order on Reconsideration. The Referee thereby assessed a $750 attorney fee pursuant to ORS 656.382(1).

The employer contends that there has been no unreasonable resistance to the payment of the reconsideration order award because the payment of the award was stayed pursuant to ORS 656.313, when the employer timely requested a hearing regarding the reconsideration order. We agree that the employer cannot unreasonably resist the payment of compensation that has been lawfully stayed. Furthermore, there is no basis nor amounts of compensation then due upon which to base a penalty. Accordingly, the Referee's $750 assessed attorney fee under ORS 656.382(1) is reversed.

Inasmuch as claimant submitted no brief, he is not entitled to an attorney fee on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated July 15, 1993 is affirmed in part and reversed in part. The Referee's $750 attorney fee award under ORS 656.382(1) is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MYRNA L. TAYLOR, Claimant
WCB Case No. 93-05023
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Westerband, Haynes and Gunn

Claimant requests review of Referee Holtan's order which: (1) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's low back condition; and (2) declined to assess a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability and penalties.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated July 28, 1993 is affirmed.

Board Member Gunn, dissenting.

The majority concludes that claimant is not entitled to an award of unscheduled permanent disability. Because I believe that the persuasive medical evidence establishes that claimant is entitled to an award of permanent disability, I dissent.

The majority relies on the opinion of Dr. Bald who performed an independent medical examination. Dr. Bald, who is an orthopedic surgeon and not a psychologist, reported that claimant exhibited limited ranges of motion, but Dr. Bald attributed these restrictions to a "major psychogenic component" and not the compensable injury. Claimant's attending physician, Dr. Scoltock, did not offer an opinion regarding claimant's permanent impairment, but merely concurred, without comment, with Dr. Bald's opinion.

Dr. Mead, who is a neuropsychiatrist, was appointed as a medical arbiter by the Appellate Unit. The Appellate Unit sent Dr. Mead a lengthy letter explaining what information it need and what information should be considering in evaluating claimant's permanent impairment. Dr. Mead also reported that claimant had restricted ranges of motion in her low back. While Dr. Mead did diagnose moderate functional overlay, he did not attribute claimant's range of motion limitations to a psychological component.

When there is a dispute between medical experts, we rely on those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). As noted above, Dr. Mead is a neuropsychiatrist. Moreover, Dr. Mead was fully informed by the Appellate Unit as to what information should be considered relevant to rating claimant's permanent impairment under the standards. On this record, I find Dr. Mead more persuasive than Dr. Bald. Consequently, I would conclude that claimant has established entitlement to permanent disability benefits. Therefore, I dissent.

In the Matter of the Compensation of
JANE A. VOLK, Claimant
WCB Case No. 92-06678
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Pursuant to an April 1, 1994 Order on Review, the majority of the Board held that claimant's counsel was entitled to an "out-of-compensation" attorney fee, but, since the compensation had previously been paid to claimant, declined to direct the insurer to pay the fee directly to claimant's counsel. Asserting that the Board's decision is inconsistent with several appellate court holdings and contrary to OAR 438-15-085(2), claimant seeks reconsideration.

In order to further consider claimant's contentions, we withdraw the Board's April 1, 1994 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK N. ANDERSON, Claimant
WCB Case No. 92-08163
ORDER ON REVIEW
Acculaw, P.C., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband, Hall and Haynes.

The insurer requests review of that portion of Referee Baker's order that found the loose body in claimant's right knee compensable. Contending that no claim was made for that condition prior to hearing, the insurer argues that claimant's hearing request concerning that condition was premature and, therefore, the Referee was without jurisdiction to hear the issue. In his respondent's brief, claimant challenges those portions of the Referee's order that: (1) failed to address the compensability of claimant's right knee chondromalacia and femoral condyle crater conditions; and (2) declined to assess penalties and attorney fees for the insurer's alleged "de facto back-up denial." On review, the issues are jurisdiction, compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

On May 11, 1992, Dr. Carlsen, claimant's treating orthopedist, noted swelling and a loose body in the right knee joint. He diagnosed synovitis and a possible torn medial meniscus, and referred claimant for an MRI. The MRI confirmed a small meniscus tear and loose body (tentatively identified as a meniscal fragment) within the knee joint.

Claimant was examined for the insurer by orthopedist Fuller on June 2, 1992. Dr. Fuller reviewed the MRI, and agreed that claimant had a small meniscus tear; however, he was uncertain whether there was a loose body in claimant's knee joint. Dr. Fuller opined that the synovitis was related to work activities, but that the torn meniscus was not.

Thereafter, the insurer denied the meniscus tear on June 11, 1992, and formally accepted "anterior synovitis" as a disabling injury on June 15, 1992. The insurer neither specifically accepted nor denied the loose body condition.

On June 23, 1992, claimant underwent arthroscopic surgery, during which Dr. Carlsen found a partial medial meniscus tear; chondromalacia of the medial femoral condyle, the lateral tibial condyle and the patellofemoral surface; a femoral condyle crater; and a loose body of cartilage which had broken off from the femoral condyle. The insurer received copies of the operative records on July 10, 1992.

The Referee held a pre-hearing telephonic conference with the parties' counsel on September 8, 1992. During the conference, claimant's attorney indicated that claimant was contending that all conditions diagnosed by Dr. Carlsen at the June 1992 surgery were compensable. When the hearing convened on September 10, 1992, claimant's attorney asserted, for purposes of clarification, that claimant was contending that all conditions diagnosed by Dr. Carlsen, except the meniscus tear, were compensable. The insurer then moved to dismiss. Noting that claimant had conceded that the only condition denied by the insurer (the meniscus tear) was not compensable, the insurer argued that the other "claimed" conditions were not yet "ripe" for hearing. The insurer declined the Referee's invitation to identify which conditions it would accept or deny, asserting that it was neither in a position to do so at hearing, nor obligated to do so as 90 days had not yet passed.

The Referee deferred ruling on the insurer's motion, and permitted the hearing to proceed. At the close of the hearing, the insurer again moved to dismiss. The Referee denied the insurer's motion, and found the right knee loose body compensable. The Referee did not address claimant's claims for chondromalacia or femoral condyle crater conditions.

CONCLUSIONS OF LAW AND OPINION

Loose Body

On review, the insurer renews its contention that claimant's hearing request concerning the loose body should have been dismissed because it was premature and, therefore, void. We disagree.

The statutory scheme does not permit a hearing on compensability of a claim prior to a timely acceptance or denial or prior to expiration of the time in which the insurer may investigate and consider the claim without risking penalties. A prematurely filed request for hearing is ineffective and void. Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981); Michael A. Dipolito, 44 Van Natta 981 (1992). A claim is deemed denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). Safeway Stores, Inc. v. Smith, 117 Or App 224 (1993); Barr v. EBI Companies, 88 Or App 132 (1987); Syphers, 51 Or App at 771.

Therefore, in order to resolve the issue of whether claimant's hearing request was premature, it is first necessary to determine if a claim for a loose body condition was made at least 90 days before hearing. If it was, then the Referee had jurisdiction over a "de facto" denial, even if no formal denial issued.

On this record, we find that a claim for a loose body condition was made at least 90 days before hearing. Dr. Carlsen noted a loose body in his May 11, 1992 chartnote; the May 14, 1992 MRI diagnosed a loose body within the knee joint; and examining orthopedist Fuller's June 2, 1992 report to the insurer indicated that claimant might have a loose body in his knee joint. Contrary to the insurer's assertion that no "claim" was made for a loose body prior to hearing, we find that the same medical reports that gave rise to the insurer's June 11, 1992 denial, also constituted a "claim" for the loose body condition. From June 11, 1992, the insurer had 90 days within which to accept or deny the claim. Because it did neither, the claim was "de facto" denied.

Consequently, by the date the hearing convened on September 10, 1992, 90 days had passed since the loose body claim was presented. Therefore, the Referee had jurisdiction to reach the compensability issue.

Turning to the merits, the medical evidence establishes that claimant's work activity on April 27, 1992 caused a piece of cartilage to break off from the femoral condyle in the knee joint. Accordingly, we adopt and affirm the Referee's reasoning and conclusion that claimant's right knee loose body condition is compensable.

Chondromalacia and Femoral Condyle Crater

On review, claimant contends that the Referee also should have found the right knee chondromalacia and femoral condyle crater conditions compensable. We find that claimant's hearing request concerning these conditions was premature. Therefore, the Referee did not have jurisdiction to address the compensability of the right knee chondromalacia and femoral condyle crater conditions.

Claimant's chondromalacia and femoral condyle crater were first diagnosed during arthroscopic surgery on June 23, 1992. Because the insurer first received copies of the operative records on July 10, 1992, that was the earliest date on which it had notice or knowledge of "claims" for chondromalacia and a femoral condyle crater. From July 10, 1992, the insurer had 90 days within which to accept or deny the claim. ORS 656.262(6).

Here, the hearing was held on September 10, 1992, well before expiration of the 90 days from the July 10, 1992 "claim" date. Inasmuch as there is no evidence in the record that a denial (oral, written or "de facto") issued concerning the chondromalacia and femoral condyle crater conditions, it was premature for the Referee to address these issues over the insurer's objection. Syphers, supra. Therefore, the Referee did not have jurisdiction to address those issues.

Penalties and Attorney Fee/Hearing

On July 22, 1992, claimant filed a supplemental request for hearing concerning the insurer's alleged June 11, 1992 "back-up de facto" denial. The insurer denied the meniscus tear on June 11, 1992, and formally accepted synovitis as a disabling injury on June 15, 1992. The insurer's June 15, 1992 notice was the first acceptance it issued. We find no basis to characterize the insurer's June 11, 1992 written denial as either a "de facto" or "back-up" denial. Consequently, we too decline to assess a penalty.

Attorney Fee on Review

Claimant's attorney is entitled to an assessed attorney 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 regarding the compensability of the loose body condition is $450, 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 17, 1993 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $450, to be paid by the insurer.

Board Member Haynes dissenting, in part:

The majority finds that claimant made a "claim" for a loose body condition by at least June 11, 1992. It concludes, therefore, that because the insurer first had notice or knowledge of the claim at least 90 days before hearing, the Referee had jurisdiction to reach the compensability issue.

On this record, I would instead find that the insurer first had notice or knowledge of the loose body claim when it received copies of the arthroscopic surgery report on July 10, 1992. The medical reports authored prior to that time were speculative and equivocal at best as to the existence of a loose body in claimant's knee joint and, if one existed, the source of the suspected loose body; i.e., whether it was compensable or due to one of claimant's noncompensable knee conditions.

On May 11, 1992, Dr. Carlsen noted that the x-rays show "perhaps" a loose body in the right knee joint. A May 14, 1992 MRI revealed numerous conditions, among them a loose body, thought possibly to represent a meniscus fragment. After reviewing the MRI, Dr. Fuller was uncertain whether there was a loose body in claimant's knee joint. It was not until claimant underwent arthroscopic surgery, that Dr. Carlsen was able to determine that there was in fact a loose body in the knee joint, or that it was a portion of femoral condyle cartilage.

Because the arthroscopic surgery report was the first medical report to diagnose without equivocation the existence of and source of the suspected loose body, I would find that that report constitutes the first notice to the insurer that claimant was making a claim for a loose body condition. The insurer was not obligated either to accept or deny that claim prior to expiration of 90 days from July 10, 1992. ORS 656.262(6).

When the hearing convened on September 10, 1992, 90 days had not yet passed since the loose body claim was presented. Consequently, claimant's hearing request concerning this "claim" was premature, and the Referee did not have jurisdiction to consider the loose body claim. For these reasons, I respectfully dissent from that portion of the order finding claimant's right knee loose body condition compensable.

In the Matter of the Compensation of
MARILYN M. BARR, Claimant
WCB Case No. 92-15594
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Nichols' order which affirmed an Order on Reconsideration's awards of 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist) and 23 percent (5.06 degrees) scheduled permanent disability for loss of use or function of the left middle finger. On review, the issues are extent of scheduled permanent disability.

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

The only issue on review is whether claimant is entitled to an award of scheduled permanent disability for loss of grip strength in the right hand. The Referee determined that she was not because neither claimant's treating physician, Dr. Scheinberg, nor the medical arbiter, Dr. Rand, believed that their grip strength measurements were valid. Claimant contends that the totality of the medical evidence, as well as her testimony, supports a finding that she has sustained a permanent loss of grip strength in the right hand. We disagree.

Permanent impairment is established by a preponderance of the medical evidence, considering the arbiter's examination as well as any prior relevant impairment findings. See Carlos S. Cobian, 45 Van Natta 1582 (1993); Raymond L. Owen, 45 Van Natta 1528 (1993). Lay testimony is insufficient to establish permanent impairment under the "standards." See Patricia A. Avila, 45 Van Natta 2094 (1993); William K. Nesvold, 43 Van Natta 2767 (1991). In determining whether a claimant has permanent impairment, we rely on the most thorough, complete and well-reasoned evaluation of claimant's permanent impairment. Carlos S. Cobian, supra.

In this case, we find that Dr. Scheinberg provided the most persuasive evaluation of claimant's grip strength. Although Dr. Rand rated claimant's loss of grip strength as 4/5 due to "lack of effort," this report is not very persuasive. (Ex. 18). Dr. Rand's original medical arbiter's report did not mention lack of cooperation (Ex. 17), and he provided no explanation in his later report for his conclusion that claimant did not give a full effort on grip strength testing.

On the other hand, Dr. Scheinberg performed a closing examination on January 9, 1992, in which he commented that claimant "appears to have weakness in the grip of the right hand compared to the left." (Ex. 13). However, he considered this to be a subjective finding. In a subsequent examination on March 20, 1992, Dr. Scheinberg again measured claimant's grip strength. (Ex. 14). He noted once more that claimant appeared to have loss of grip strength, but that "giving way" made his testing to be "somewhat questionable." Claimant contends that this comment should not preclude a finding of lost grip strength given his clinical findings.

We disagree. Not only did Dr. Scheinberg state that claimant's testing was "somewhat questionable," but he also wrote that "I suspect that the actual grip strength on both sides is 5/5, but again the giving way clouded the examination. Intrinsic function certainly appeared to be normal at 5/5 in both hands." Based on those comments, we find that claimant's alleged loss of grip strength is more than "somewhat questionable." We interpret Dr. Scheinberg as concluding that claimant's grip strength is, in fact, normal. Inasmuch as it is the most thorough and complete analysis of claimant's grip strength, we give Dr. Scheinberg's March 20, 1992 medical report the greatest weight. See Somers v. SAIF, 77 Or App 259 (1986).

In light of Dr. Scheinberg's conclusions, claimant has failed to prove by a preponderance of the evidence that she is entitled to an award of permanent disability for loss of grip strength. Accordingly, we adopt and affirm the Referee's determination on this issue.

ORDER

The Referee's order dated August 19, 1993 is affirmed.

In the Matter of the Compensation of
CLIFFORD L. CONRADI, Claimant
WCB Case No. 92-13967
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Crumme's order that upheld the self-insured employer's denials of claimant's aggravation claim for a cervical condition and his occupational disease claim for the same condition. In his brief, claimant contends that: (1) the Referee should have denied the employer's motion to postpone the initial hearing or, in granting that motion, the Referee should have limited the medical record to the evidence submitted at the initial hearing; and (2) the Referee should have admitted Exhibit 50, a report from claimant's treating physician, into evidence. On review, the issues are postponement, evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation. Finding number 4 should read that claimant remained off work until about June 1991.

On October 21, 1992, claimant requested a hearing and raised the issue of compensability, among other issues. The hearing was scheduled for January 21, 1993.

On November 20, 1992, claimant's attorney forwarded a copy of an October 21, 1992 report from Dr. Bell, claimant's treating neurologist. (January 21, 1993 hearing transcript, pages 5-6; Ex. 42). In his cover letter, claimant's attorney requested that the employer accept the medical report as claimant's claim for an aggravation as well as an occupational disease arising from his employment with the employer. (January 21, 1993 hearing transcript, page 5). Claimant's attorney conceded that that submission was the first time an occupational disease claim had been raised. Id. at 6.

On December 9, 1992, the employer issued a denial of claimant's aggravation claim. (Ex. 44).

The employer failed to notify its attorney regarding the pending January 21, 1993 hearing. The employer's attorney did not become aware of the hearing until the day of the hearing. (January 21, 1993 hearing transcript, pages 2-3).

At the January 21, 1993 hearing, the Referee postponed the proceedings on the ground that a new claim had been filed for an occupational disease, the period of time allowed for the employer to process that new claim had not expired, and the occupational disease claim concerned the same condition as the aggravation claim. (January 21, 1993 hearing transcript, pages 6-7). The Referee denied claimant's motion to restrict the medical record to the medical evidence submitted at the time of the January 21, 1993 hearing. Id.

On March 1, 1993, the employer denied claimant's occupational disease claim. (Ex. 46).

A second hearing convened on April 16, 1993. Claimant renewed his motion that the medical record be restricted to the medical evidence submitted at the time of the January 21, 1993 hearing. In the alternative, claimant requested that he be allowed to submit rebuttal evidence in response to Exhibits 47 and 48. (April 16, 1993 hearing transcript, pages 11-12). Exhibit 47 is a report from Dr. Brown, examining neurologist, which elaborated on the doctor's earlier IME report. Exhibit 48 is a report from Dr. Zivin, M.D., who performed a record review at the request of the employer.

The Referee denied claimant's renewed motion that the medical record be frozen as of the January 21, 1993 hearing and admitted Exhibits 45, 46, 47, and 48. (April 16, 1993 hearing transcript, page 16). The Referee granted claimant's request to submit rebuttal evidence to Exhibits 47 and 48 and allowed the employer an opportunity to cross-examine the author of the rebuttal report, if the employer wished to do so. Id. at 15. The Referee requested a time limit for submission of the rebuttal report and claimant's attorney suggested 30 days. Id. at 18.

By letter dated April 19, 1993, the Referee advised the parties' attorneys of the various rulings he had made at the April 16, 1993 hearing. This summary included the Referee's ruling that claimant's motion for a continuance to offer a medical report to rebut Exhibits 47 and 48 was granted and that claimant had 30 days to file that report.

A third hearing convened on June 14, 1993. At hearing, claimant's attorney offered Exhibit 50, which was a report from Dr. Bell, claimant's treating physician, dated May 28, 1993, and received by claimant's attorney on June 11, 1993. (June 14, 1993 hearing transcript, pages 4-6). The employer objected to the admission of Exhibit 50 on the ground that it was submitted past the 30-day deadline given at the April 1993 hearing. Id. at 6-7. The Referee sustained that objection and declined to admit Exhibit 50. Id. at 7.

CONCLUSIONS OF LAW AND OPINION

Postponement

On review, claimant argues that the Referee erred in postponing the January 21, 1993 hearing. We find that the Referee properly allowed postponement of the hearing.

ORS 656.283(4) provides that a "hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party." OAR 438-06-081 implements ORS 656.283(4) and provides that a scheduled hearing "shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." See Georgia-Pacific Corp. v. Kight, 126 Or App 244 (1994).

Claimant notes that, pursuant to OAR 438-06-081(1), "extraordinary circumstances" does not include the employer's failure to notify its attorney about this case and the scheduled hearing. We agree with claimant's statement of law and, if the Referee had postponed the January 21, 1993 hearing on those grounds, we would find such a postponement improper. ORS 656.283(4); OAR 438-06-081(1).

However, although it is true that the employer failed to notify its attorney regarding the scheduled hearing, that is not the reason the Referee postponed the January 21, 1993 hearing. Instead, the Referee postponed the January 21, 1993 hearing on the grounds that a new claim for an occupational disease had been made and the employer was still within the 90-day period for processing that claim. In addition, the Referee found that the occupational disease claim and the aggravation claim were for the same cervical condition.

Claimant's attorney conceded at hearing that an occupational disease claim was first filed with his November 20, 1992 submittal of a October 21, 1992 report from Dr. Bell, treating neurologist. The employer had 90 days to process this new claim. ORS 656.262(6). At the time of the January 21, 1993 hearing, that 90-day period had not expired.

Claimant notes that, on December 9, 1992, the employer had denied his cervical condition as a component of his accepted low back injury. He argues that the Referee should have proceeded at the January 21, 1993 hearing on that aggravation issue, without combining the two claims for a hearing at a later date. However, as found by the Referee, both the aggravation claim and the occupational disease claim involved the same cervical condition. These claims simply involved different theories of compensability. Therefore, we find it appropriate that these claims be heard together.

Our finding is supported by OAR 438-06-065(1)(b) which provides for mandatory consolidation of cases "in which a claimant has requested hearings involving more than one claim, regardless of date of injury, against the same employer. . ." where "the referee finds that consolidation is necessary or desirable for full determination of the issues." Here, although claimant had not requested multiple hearings at the time of the January 21, 1993 hearing, he had filed multiple claims against the same employer involving the same cervical condition.

Since the occupational disease claim was filed approximately two months before the hearing on the employer's aggravation denial, the employer's 90-day "investigation period" had not expired by the time of the January 1993 hearing. Thus, the employer's response to the occupational disease claim was pending at the time of the scheduled hearing. Considering the parties' respective positions at the hearing, it is apparent that litigation of the occupational disease claim was inevitable.

Under such circumstances, we are persuaded that the Referee's decision achieved substantial justice and administrative economy. Moreover, we find that the circumstances of this case present "extraordinary circumstances" beyond the control of the employer, the party requesting postponement, which justified postponement of the January 21, 1993 hearing. ORS 656.283(4); OAR 438-06-081.

Evidence

The Referee refused to limit the medical evidence in the reconvened hearing to that submitted at the January 21, 1993 hearing, reasoning that the employer was entitled to 90 days within which to process the new occupational disease claim which may necessarily require the employer to seek medical evidence. (January 21, 1993 hearing transcript, pages 6-7). On review, claimant argues that the medical record should have been restricted to the evidence submitted at the January 21, 1993 hearing.

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).

As discussed above, we have found "extraordinary circumstances" in this case that justified the postponement of the January 21, 1993 hearing. Furthermore, following the postponement, the aggravation and occupational disease claims were to be heard together during the rescheduled April 16, 1993 hearing. In light of the postponement, it would have been improper to limit the evidence to that obtained as of January 21, 1993 when the employer was still within the processing period regarding the newly submitted occupational disease claim at that time. Furthermore, the Referee placed no restrictions on the evidence to be presented at the rescheduled hearing. Therefore, claimant was also able to present new evidence at the rescheduled hearing. Under these circumstances, we do not find that the Referee abused his discretion in refusing to restrict the medical record to that developed at the time of the January 21, 1993 hearing.

The only evidentiary question that remains concerns the admissibility of Exhibit 50. We find that the Referee properly excluded that exhibit.

A referee may continue a hearing 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. See OAR 438-06-091(3); David F. Grant, 42 Van Natta 865 (1990). Further, OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests with a referee's discretion. Sue Belluci, 41 Van Natta 1890 (1989).

Here, the second hearing convened on April 16, 1993. At that hearing, the Referee admitted Exhibits 1 through 48. Because the employer had submitted Exhibits 47 and 48 less than 20 days from the date of hearing, the Referee continued the hearing to allow claimant to submit rebuttal evidence regarding those exhibits. In addition, the Referee allowed the employer to cross-examine the author of claimant's rebuttal evidence, if the employer so desired. The Referee requested that the rebuttal evidence be submitted within a specific time period and claimant's attorney suggested 30 days. (April 16, 1993 hearing transcript, page 18).

By letter dated April 19, 1993, the Referee advised the parties' attorneys of the various rulings he had made at the April 16, 1993 hearing. This summary included the Referee's ruling that claimant's motion for a continuance to offer a medical report to rebut Exhibits 47 and 48 was granted and that claimant had 30 days to file that report.

The third hearing convened on June 14, 1993. At that hearing, claimant submitted Exhibit 50, a report from Dr. Bell which was dated May 28, 1993, but received by claimant's attorney on June 11, 1993. (June 14, 1993 hearing transcript, pages 4-6). The Referee excluded Exhibit 50 on the basis that a firm date for submission of claimant's rebuttal report had been set at the April 1993 hearing and that deadline had not been met.

We conclude that it was not an abuse of discretion for the Referee to continue the hearing for receipt of claimant's rebuttal evidence and to set a specific deadline within which claimant was to file

that evidence. Furthermore, because claimant did not meet that deadline, it was not an abuse of discretion for the Referee to refuse to admit the rebuttal evidence. Compare Darrel L. Hunt, 44 Van Natta 2582 (1992) (where a referee leaves the record open for a limited purpose, it is within the referee's discretion to exclude evidence that does not comport with that purpose). Furthermore, we note that it was claimant's attorney who suggested the 30-day deadline.

Alternatively, even if Exhibit 50 were admitted, the result regarding the compensability issue would be the same. We agree with the Referee that Dr. Bell's previous opinions are not persuasive because they are inconsistent, conclusory, and based on an inaccurate understanding of claimant's work activities. (Exs. 33, 41, 42). Exhibit 50 does not correct these problems.

Exhibit 50 does not address the issue raised by the examining physicians that the cause of claimant's cervical condition was normal degenerative changes unrelated to work. Furthermore, Exhibit 50 does not explain Dr. Bell's inconsistent opinions regarding causation. Without explaining his changes of opinion, Dr. Bell has opined that claimant's cervical condition was caused by: (1) a new work injury; (2) the November 30, 1990 work injury; and (3) claimant's ongoing work activities. (Exs. 33, 41, 42). There is no evidence of any new work injury and Dr. Bell has an inaccurate history of claimant's work activities. In Exhibit 50, again without explanation, Dr. Bell returned to his second causation opinion that claimant's cervical condition is caused by the November 30, 1990 work injury.

In Exhibit 50, Dr. Bell notes that his April 21, 1991 chart note reflects morning stiffness in claimant's hands which he believes "relates to the original cervical condition [claimant] complained of." However, Dr. Bell does not explain how this relates to the cervical condition. At the time, Dr. Bell considered inflammatory arthritis as a possible cause of claimant's hand symptoms. (Ex. 20). These are not the symptoms of neck pain radiating down the left arm with occipital headaches that claimant first reported in July and August 1992 which led Dr. Bell to diagnose a cervical strain syndrome. (Exs. 20, 32, 33).

Furthermore, Dr. Bell states in Exhibit 50 that claimant's low back pain was the reason claimant "did not complain of neck pain quite so vigorously initially." (Ex. 50). However, there are no complaints of neck pain in the medical record until Dr. Bell's July and August 1992 chart notes. (Exs. 32, 33).

Given these problems with Exhibit 50, even if it were admitted, it would not establish the compensability of claimant's cervical condition.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability issue.

ORDER

The Referee's order dated July 13, 1993 is affirmed.

In the Matter of the Compensation of
ROBIN L. DEAN, Claimant
WCB Case No. 93-08845
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Referee Hoguet's order that awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.386(1) when SAIF withdrew its request for hearing concerning an Order on Reconsideration. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's counsel was instrumental in obtaining compensation for claimant based on SAIF's withdrawal of its hearing request concerning the July 20, 1993 Order on Reconsideration. Therefore, the Referee concluded that claimant's counsel was entitled to an assessed attorney fee pursuant to ORS 656.386(1). We disagree.

In Kim M. Harrison, 44 Van Natta 371 (1992), we held that the claimant was not entitled to an attorney fee pursuant to ORS 656.386(1) where a carrier had withdrawn its request for hearing concerning a permanent disability granted by a reconsideration order. In Harrison, supra, we noted that the claimant's counsel may well have been instrumental in prompting the carrier's withdrawal of its hearing request. However, we reasoned that the claimant's counsel's efforts and the carrier's withdrawal of its hearing request did not result in the claimant "obtaining" compensation without a hearing. Id. at 372. Rather, we concluded that the carrier's withdrawal of its hearing request removed the threat of reduction of claimant's benefits as granted by the reconsideration. Consequently, we determined that such circumstances did not entitle claimant to an attorney fee award under ORS 656.386(1). Id.

While the compensation in Harrison, supra was permanent disability compensation, we find it applicable to the present situation. Here, the Order on Reconsideration set aside the Notice of Closure as premature. Thus, claimant became entitled to further temporary disability benefits and an eventual reclosure and redetermination of his claim. SAIF's request for hearing concerning the premature closure issue did pose a "threat" of reduction of claimant's temporary disability benefits. However, the withdrawal of SAIF's hearing request did not result in claimant "obtaining" compensation without a hearing. Claimant's counsel did not obtain compensation for claimant as is required under ORS 656.386(1). Consequently, as in Harrison, claimant's counsel is not entitled to an assessed attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated September 27, 1993 is reversed. The Referee's award of a $500 assessed attorney fee is reversed.

In the Matter of the Compensation of
IVAN G. DOOLEY, Claimant
WCB Case No. 92-15789
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of those portions of Referee Peterson's order which: (1) affirmed the Order on Reconsideration's award of 37 percent (118.4 degrees) unscheduled permanent disability for neck and back conditions and 12 percent (18 degrees) scheduled permanent disability for loss of use or function of the right forearm; and (2) awarded claimant's counsel an assessed attorney fee of $3,000 under ORS 656.382(2) for successfully defending against the insurer's request for hearing. On review, the issues are extent of disability (both unscheduled and scheduled) and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

On August 23, 1991, claimant sustained compensable injuries to his head, neck, low back and right wrist. An orthopedist, Dr. Noall, became claimant's attending physician. Dr. Noall released claimant to "full regular work" on December 12, 1991. (Ex. 17-2). At the time, Dr. Noall noted that claimant's upper back range of motion was "almost complete."

On February 3, 1992, Dr. Noall reported that claimant was working full time, but that he was experiencing soreness in the wrist, upper back and neck. Although claimant demonstrated full flexion and extension, lateral bending each way was 50 percent of normal. (Ex. 17-2). Dr. Noall continued to recommend that claimant perform regular work.

Dr. McKillop, an orthopedic surgeon, examined claimant for the insurer on April 22, 1992. (Ex. 18). After measuring significant reductions in cervical and lumbar ranges of motion, Dr. McKillop commented as follows:

> "There are some inconsistencies in his exam, in that his ranges of motion seem to be quite restricted, although Dr. Noall indicated that his motions were quite good. I suspect that his ranges of motion are so greatly affected by the accompanying discomfort that one cannot depend on the actual measurements as being very accurate. He very likely would have a better range of motion later in the day. This exam was performed in the morning."

Dr. McKillop also commented: "Overall, he has made a pretty good recovery from his injury, but probably has some minimal to mild impairment of his cervical and lumbar spine areas from this injury." (Ex. 18-9). Dr. Noall agreed with Dr. McKillop's report on May 11, 1992. (Ex. 19).

The insurer arranged another examination with an orthopedist, Dr. Duff, on July 1, 1992. Dr. Duff reported that claimant was working full time without restrictions. (Ex. 22). Dr. Duff also wrote that claimant's decreased lumbar and cervical ranges of motion were not consistent with his injury and reflected a "lack of maximal effort in demonstrating range of motion." Dr. Duff concluded that claimant's limitations were not truly valid.

Dr. Noall also concurred with this report. (Ex. 23). The claim was then closed by Determination Order of August 12, 1992, with an award of 4 percent scheduled permanent disability for loss of use or function of the right wrist. No unscheduled award was made because of Dr. McKillop's and Dr. Duff's comments regarding the validity of their measurements of claimant's cervical and lumbar ranges of motion. (Ex. 24).

Claimant requested reconsideration, including appointment of a medical arbiter. On November 11, 1992, Dr. Dinneen, an orthopedist, performed an arbiter's examination. Noting that claimant had been previously examined by Drs. McKillop and Duff, Dr. Dinneen measured claimant's range of motion for his wrist, low back and cervical spine. Dr. Dinneen concluded that there was evidence to suggest "minimal impairment with repeated use of the right wrist which can reasonably be attributed to the chronic and permanent condition arising out of the August 23, 1991 incident." (Ex. 28-3). Dr. Dinneen also opined that claimant could work in "at least the light/medium category." (Ex. 28-4).

Based on the arbiter's examination, a November 17, 1992 Order on Reconsideration awarded claimant 12 percent scheduled permanent disability. This included 5 percent scheduled disability for a "chronic condition." (Ex. 29). The evaluator also calculated claimant's unscheduled impairment as 29, based on Dr. Dinneen's measurements of claimant's lumbar and cervical ranges of motion. The evaluator then multiplied the sum of claimant's age and education values (2) by an adaptability value of 4, based on the difference between the greatest strength necessary to perform claimant's pre-injury employment and a residual functional category of light/medium, to arrive at a product of 8. Adding this figure to claimant's impairment value of 29, the evaluator determined claimant's unscheduled permanent disability to be 37 percent. The insurer appealed the award.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

Permanent Impairment

The Referee relied on Dr. Dinneen's medical report in affirming the calculation of claimant's permanent impairment in the reconsideration order. Rejecting the insurer's argument that claimant had no valid losses of range of motion in the cervical and lumbar spine, the Referee concluded that that there was no preponderance of medical evidence which established a level of impairment other than what Dr. Dinneen, the medical arbiter, had found. See OAR 436-35-007(9).

The insurer contends that claimant does not have any measurable permanent impairment because all of the measurements of claimant's ranges of motion were invalid. At most, the insurer asserts, claimant has only episodic losses of range of motion which do not represent permanent impairment. See Trina M. Trana, 42 Van Natta 2394 (1992). We disagree.

Although Drs. McKillop and Duff questioned the validity of their measurements, we do not find a preponderance of medical evidence which establishes a different level of impairment from what the medical arbiter, Dr. Dinneen, determined. Moreover, we do not consider claimant's reductions in range of motion to be episodic considering that all physicians, including Dr. Noall, have reported reduced range of motion. The real issue here is whether Dr. Dinneen's range of motion findings were reliable. We conclude that they were.

First, Dr. Dinneen was clearly aware of the findings in Drs. McKillop's and Duff's medical reports. Dr. Dinneen specifically referred to those examinations in his own report. (Ex. 28-2). It is reasonable to conclude that Dr. Dinneen was aware of the questions concerning the validity of claimant's ranges of motion and that, had he any doubts as to the reliability of his own findings, Dr. Dinneen would have so noted in his report. However, there is no indication that Dr. Dinneen questioned the validity of his range of motion findings.

Second, there is no medical evidence that rules out permanent impairment due to claimant's compensable injury. Indeed, Dr. McKillop conceded that claimant did have permanent impairment in his cervical spine. (Ex. 18-9). In addition, Dr. Duff never stated that claimant did not have permanent impairment. We also note that, after Dr. Noall reported that claimant's range of motion of his upper back was "almost complete," he wrote that claimant had only 50 percent of normal lateral bending. (Ex. 17-2).

In light of these medical reports, we do not find that a preponderance of medical evidence establishes a level of impairment different from what the medical arbiter found. The Referee, therefore, properly relied on the medical arbiter's report in evaluating claimant's unscheduled impairment. Accordingly, we affirm the Referee's decision on this issue and find that claimant has an impairment value of 29.

Adaptability

The insurer contends that the Referee erred in adopting the adaptability value of 4 that was assigned to claimant in the November 17, 1992 Order on Reconsideration. The Department had based this value on the difference between the highest prior strength required in jobs claimant performed in the ten years preceding the time of determination (heavy) and the maximum residual capacity at the time of determination (light-medium). The insurer asserts that claimant's residual functional capacity remains at the level of heavy strength, thereby requiring an adaptability factor of 1 under the temporary rules effective June 17, 1993. See WCD Admin. Order 93-052.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2); See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant became medically stationary on March 2, 1992, and his claim was closed by Determination Order on August 12, 1992. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the Determination Order. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 6-1992. Thus, the issue is what value for adaptability, if any, claimant is entitled to under the relevant standards.

The pertinent administrative rule is OAR 436-35-310(2) (WCD Admin. Order 6-1992), which provides that, for workers that have a release to regular work or have either returned to or have the residual functional capacity to perform regular work, the value for the factor of adaptability is zero. Here, claimant's at-injury job was a millwright. He was released by his attending physician, Dr. Noall, to his regular work with absolutely no restrictions. (Ex. 17). We are mindful that the medical arbiter, Dr. Dinneen, opined that claimant was capable of work in "at least the light/medium category." (Ex. 28). However, we do not interpret this statement as necessarily restricting claimant's return to work to the light/medium level.

Accordingly, since claimant was released to return to his regular millwright duties without restriction, we conclude that his adaptability value is zero under the applicable standards. See Mark S. Lillibridge, 46 Van Natta 411 (1994). Therefore, we disagree with the Referee's evaluation of the extent of claimant's unscheduled permanent disability.

Because the adaptability factor is a multiplier, the product of claimant's age and education factors with his adaptability equals zero. Accordingly, claimant's unscheduled permanent disability is based on permanent impairment alone. Since we have determined that the reconsideration order correctly calculated claimant's permanent impairment value as 29, we conclude that claimant's unscheduled permanent disability award is 29 percent. We modify claimant's award accordingly.

Scheduled Permanent Disability

The insurer contends that the Referee erred in affirming the 12 percent scheduled permanent disability award granted in the Order on Reconsideration. The reconsideration order based its award on Dr. Dinneen's medical arbiter's report, which documented reduced range of wrist motion and stated there was evidence to suggest that claimant had minimal impairment with repeated use of the wrist that could be attributed to a chronic and permanent condition arising out of claimant's injury.

For the reasons previously discussed, we accept the range of motion findings in Dr. Dinneen's arbiter's report. However, we do not find Dr. Dinneen's report sufficient to establish the presence of a chronic condition limiting repetitive use of his right wrist. In order for claimant to receive a "chronic condition" award, there must be medical evidence of at least a partial loss of ability to repetitively use the body part. See Donald E. Lowry, 45 Van Natta 1452, 1453 (1993).

Dr. Dinneen does not state, however, that claimant is limited in his ability to repetitively use his right wrist. He only states that claimant has "minimal impairment" with repeated use of the wrist. Without more explanation, we are unable to conclude that "minimal impairment" means that there is a partial loss of repetitive use of the wrist.

Moreover, Dr. Dinneen does not provide sufficient medical evidence to support such a finding. In his examination, Dr. Dinneen reported that claimant's wrist range of motion was "somewhat decreased" and that right wrist strength was "slightly reduced." (Ex. 28-3). Considering that claimant never testified, and that Dr. Dinneen never explained how these findings affected claimant's ability to repetitively use his wrist, we are unable to conclude, based on this record, that claimant has sustained his burden of proving that he has a chronic condition which limits repetitive use of his right wrist. Accordingly, claimant is not entitled to a 5 percent chronic condition award. See ORS 656.266. We, therefore, reduce claimant's scheduled permanent disability award from 12 percent to 7 percent.

Attorney Fees

The insurer contends that, if claimant's permanent disability awards are reduced on appeal, the Referee's award of an assessed attorney fee of $3,000 should be reversed. Since we have reduced both claimant's unscheduled and scheduled permanent disability awards on review, we agree that claimant is not entitled to an assessed attorney fee. See ORS 656.382(2). Accordingly, we reverse the Referee's assessed attorney fee award.

ORDER

The Referee's order dated July 8, 1993, is modified in part and reversed in part. That portion which awarded claimant's counsel an assessed attorney fee is reversed. Claimant's unscheduled permanent disability award is reduced from 37 percent (118.4 degrees), as granted by the Order on Reconsideration, to 29 percent (92.8 degrees) and claimant's scheduled permanent disability award for loss of use or function of the right forearm is reduced from 12 percent (18 degrees) to 7 percent (10.5 degrees).

In the Matter of the Compensation of
ANTONIO GARCIA, Claimant
WCB Case No. 93-07379
ORDER ON REVIEW
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Hall.

Claimant requests review of Referee Brazeau's order that: (1) held that the SAIF Corporation properly terminated temporary disability benefits under ORS 656.268(3); and (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable termination of benefits. On review, the issues are temporary disability, penalties and attorney fees.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated August 27, 1993 is affirmed.

Board Member Hall dissenting.

The Referee and the majority found that SAIF complied with the requirements for terminating temporary disability benefits under ORS 656.268(3) by offering claimant a modified job. Since I do not agree that the activity to which claimant returned constituted a return to "modified employment," I respectfully dissent.

Claimant was employed as a treeplanter. He had neither a car nor a license to drive. At the time claimant was hired, the employer agreed to provide transportation from claimant's Salem home to various job sites in the mountainous regions of western Oregon. In fact, the employer provided transportation for all its workers in a company-owned vehicle because the treeplanting contracts generally prohibited employee vehicles from the job sites.

On March 30, 1993, claimant compensably injured his right knee, right hand and back. SAIF accepted the injury claim and began paying compensation, including temporary total disability benefits. Claimant was treated conservatively and released to light modified duty as of April 9, 1993. At that time, claimant was not medically stationary and the claim was not closed.

Upon receipt of claimant's modified work release, the employer notified claimant in writing that a modified job was available at the employer's home near Philomath, which is about a one-hour drive from Salem. The work consisted of pulling weeds and maintaining equipment. Claimant agreed to accept the job. The employer provided claimant transportation to and from the job site on the first two

days. On the third day, however, the employer advised claimant that transportation would no longer be provided. Claimant arranged transportation by way of a relative through the fifth day, but he was unable to secure transportation thereafter.

Because he had no other practical means of transportation to the employer's home, claimant did not (could not) return to the modified job. Thereafter, SAIF terminated temporary disability benefits.[1]

ORS 656.268(3)(a) authorizes a carrier to terminate a worker's temporary total disability benefits (TTD) if "[t]he worker returns to. . .modified employment."

While claimant had the physical capacity to perform the activities at the employer's home, the issue is whether the carrier may terminate benefits under ORS 656.268(3) based on an offer of "modified employment" with terms and conditions that differ from those of claimant's regular job at injury to such an extent that claimant is unable, though willing, to continue in the modified activities. In other words, is "modified employment" defined only in terms of the physical requirements necessary to perform the activity? What if the "modified employment" was physically appropriate but required an advanced degree of education which the original job did not require and which the claimant did not hold?

Based on Member Gunn's persuasive dissenting opinion in Diana M. Cooper, 45 Van Natta 1211 (1993), I would conclude that the employment contract, whether express or implied, establishes the limits on the terms and conditions of modified employment. That is, a worker need not accept modified employment if the terms and conditions of that employment are not consistent with those of the employment contract prior to the injury.

One of the paramount policies underlying the workers' compensation laws is to "restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c). This policy would be frustrated if an employer could terminate a worker's benefits by offering a make-work position with terms and conditions that the worker cannot comply with. Under such circumstances, employers would be motivated not to facilitate the worker's return to work, but to establish a sham position that the worker could not accept.

Here, in my view, the terms and conditions of claimant's regular employment included the employer's provision of transportation to and from the work site. Claimant could not have performed the work without employer-provided transportation. Under these circumstances, I would rule that any modified job offered by the employer must also include the provision of transportation by the employer. In this case, the employer offered a modified job with no reliable means of transportation to and from the work site. Therefore, I would find that its modified job offer did not comply with the statute and, therefore, did not permit termination of temporary total disability benefits.

There is an additional statutory basis for reinstatement of temporary total disability benefits. ORS 656.268(3)(a) allows termination of temporary total disability benefits when the worker returns to modified employment. This provision is found within the statutory section concerning claim closure. This provision is only an intermediate or temporary step in the claim processing scheme (oftentimes for a worker who is not yet medically stationary). The social policy behind such an intermediate step is addressed above. If the injured worker is able to earn wages rather than draw benefits, such should be encouraged. Once, however, the worker is unable to continue to earn wages from such temporary modified employment (in those cases where the claim remains open and has not been processed to closure), then the temporary disability benefits should be reinstated. The statute does not allow for use of this intermediate step to permanently cut off benefits for a non-medically stationary claimant. Especially as related to payment of temporary partial disability under these circumstances, Stone v. Whittier Wood Products, 124 Or App 117 (1993), provides an answer.

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[1] It is unclear from this record whether claimant received temporary partial disability benefits for the days he actually performed work at the employer's home. In other words, it is not clear whether this case involves the termination of temporary partial disability benefits after claimant did not return to the employer's home or the failure to reinstate temporary total disability benefits upon that occasion (or both).

In the Matter of the Compensation of
JOANN OSBORN, Claimant
WCB Case No. 93-05466
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Holtan's order that awarded an assessed attorney fee under ORS 656.386(1). Claimant requests an attorney fee under ORS 656.382(1). On review, the issue is attorney fees.

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

Claimant requests an attorney fee under ORS 656.382(1), arguing that SAIF's failure to accept her claim for a herniated disc within 90 days had the effect of delaying benefits which were eventually compensable as a result of SAIF's "at-hearing" acceptance. However, in the absence of evidence that SAIF's "de facto" denial amounted to resistance to the payment of compensation, we conclude that no fee is available under ORS 656.382(1).

Finally, since attorney fees do not constitute compensation, claimant is not entitled to an attorney fee for his successful defense of the attorney fee on Board review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 13, 1993 is affirmed.

In the Matter of the Compensation of
REYNA R. ROLBAN-DUENEZ, Claimant
WCB Case No. 92-03690
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Crumee's order that: (1) found that claimant's claim was not prematurely closed; (2) upheld the insurer's denial of claimant's aggravation claim; (3) declined to award claimant permanent total disability; (4) affirmed an Order on Reconsideration awarding claimant no scheduled permanent disability (PPD) for loss of use or function of the right leg (ankle); (5) awarded claimant 12 percent (38.4 degrees) unscheduled PPD, whereas an Order on Reconsideration awarded claimant 1 percent (3.2 degrees) unscheduled PPD for a low back injury; (6) authorized the insurer to offset an overpayment of PPD against the increased PPD award; and (7) affirmed a Director's order finding claimant not eligible for vocational assistance. In addition, the insurer moves to strike claimant's reply brief. On review, the issues are motion to strike, premature closure, aggravation, extent of scheduled and unscheduled PPD (including permanent total disability), offset, and eligibility for vocational assistance. We deny the motion, affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of Fact number 16; and the second, third, and fourth sentences in Fact number 18. In addition, we supplement with the following findings.

Dr. Lee became claimant's attending physician on December 24, 1991.

At the time of the compensable injury, claimant was working as a "berry weigher"/"ticket puncher," earning $5.50 per hour.

The title in the Dictionary of Occupational Titles (DOT) that most reasonably describes claimant's regular job at injury is "farmworker, general" (DOT 421.687-010). Based on the physical demands of claimant's job at injury, her prior strength requirement was "heavy."

Claimant is unable to return to her "regular" job at-injury. Claimant has the residual functional capacity (RFC) to perform "medium" work.

The parties stipulated at hearing that the impairment value for claimant's lost thoracolumbar range of motion is one percent.

Claimant's appellant's brief was due at the Board by March 3, 1993. Because it was not filed until March 4, 1993, it was rejected as untimely. On March 26, 1993, the insurer filed its respondent's brief. Thereafter, on April 9, 1993, claimant filed her reply brief.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Contending that claimant's reply brief is a duplicate of the rejected appellant's brief, the insurer asserts that the entire reply brief should be rejected as well. We disagree.

Although the insurer stated that it was not responding, due to claimant's untimely and rejected appellant's brief, the insurer nonetheless stated that it relied on its written closing arguments which had been submitted to the Referee.

Accordingly, because the insurer relies on its written closing arguments, we conclude that claimant's reply brief may be considered. However, we consider only those portions of claimant's reply brief which respond to the issues argued in the insurer's written closing arguments. The remainder of claimant's reply brief is not considered.

Premature Claim Closure

We adopt the Referee's conclusions and reasoning as they pertain to this issue, with the following clarification.

The Referee found that Dr. Bald was claimant's attending physician at the time of the January 10, 1992 claim closure. The Referee further found that Dr. Bald had declared claimant medically stationary as of that date. In the alternative, the Referee also found that a preponderance of the medical opinion supports the conclusion that claimant's condition was medically stationary as of January 10, 1992.

Claimant contends that although the "829 Change of Attending Physician" form did not reach the insurer until after claim closure, Dr. Lee, rather than Dr. Bald, was her attending physician at claim closure. Therefore, claimant asserts, Dr. Lee's opinion that she was not medically stationary as of January 10, 1992 establishes that her claim was prematurely closed.

Claimant completed an 829 form designating Dr. Lee as her new attending physician on December 24, 1991. Dr. Lee signed the 829 on that same date, "accept[ing] the responsibility for the care and treatment of [claimant]." Thus, contrary to the Referee, we find that Dr. Lee was claimant's attending physician as of the January 1992 claim closure. See ORS 656.005(12)(b) ("attending physician" means the physician who is primarily responsible for the treatment of a worker's compensable injury).

Nevertheless, whether Dr. Lee or Dr. Bald was claimant's attending physician at claim closure is not determinative on this issue. Instead, a claim may be closed when either of two events occurs: the attending physician declares the worker medically stationary or, as is the case here, a preponderance of the medical opinion supports a finding that the worker is medically stationary. OAR 436-30-035(1). We too find claimant medically stationary on January 10, 1992 by a preponderance of the medical opinions.

Aggravation

We adopt the Referee's conclusions and reasoning as they pertain to this issue.

Permanent Total Disability

We adopt the Referee's conclusions and reasoning as they pertain to this issue.

Extent of Permanent Disability

A Determination Order awarded claimant 22 percent unscheduled PPD, and no scheduled PPD. The Order on Reconsideration reduced claimant's unscheduled award to 1 percent, based on impairment alone. The Referee increased the unscheduled award to 12 percent, based on a combined value of 7 for the age and education factors, a value of 1 for the adaptability factor, and 5 percent impairment for a chronic condition limiting repetitive use of the low back; and declined to award scheduled PPD. We reinstate and affirm the Determination Order award.

Claimant became medically stationary after July 1, 1990, and made a request for reconsideration pursuant to ORS 656.268. Therefore, the applicable standards are those in effect on the date of the January 10, 1992 Determination Order. Those standards are provided in WCD Admin. Order 2-1991. OAR 438-10-010, 436-35-003(2) (WCD Admin. Order 2-1991; WCD Admin. Order 93-056).

Extent of Scheduled Permanent Disability

Claimant argues that she is entitled to a 5 percent impairment rating for a chronic condition affecting the right ankle, as opined by Dr. Lee. As we have herein found, Dr. Lee was claimant's attending physician at claim closure. Therefore, we may consider his report in rating claimant's impairment. ORS 656.245(3); ORS 656.268(7); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

Former OAR 436-35-010(6) provides, in pertinent part:

> "A worker may be entitled to scheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition."

OAR 436-35-010(6) 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).

Claimant relies on a June 9, 1992 report from Dr. Lee in support of her argument that she has a scheduled chronic condition impairment. We do not find that Dr. Lee's "check-the-box" reply to claimant's counsel establishes a chronic condition impairment. Dr. Lee indicated only that he "anticipate[d] that claimant will have a chronic condition that limits the repetitive use of her right ankle." In this regard, we note that in his earlier reports, Dr. Lee had opined that claimant was not yet medically stationary. From the tone of the June 1992 report, we infer that he did not consider claimant stationary at that time either. Furthermore, Dr. Lee does not state that claimant has any loss of ability to repetitively use her right ankle, nor does he make findings from which we can conclude that claimant has such a loss. Therefore, on this record, claimant has failed to prove a scheduled chronic condition impairment.

Extent of Unscheduled Permanent Disability

Adaptability

The adaptability factor is based on a comparison of the prior strength demands of the worker's job at the time of injury with the worker's maximum RFC at the time of determination. Former OAR 436-35-310(1). The requirements listed in former OAR 436-35-300(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the SVP category assigned by the DOT.

The Referee found that claimant frequently lifted two or three full crates of berries at a time, with a combined weight of over 50 pounds. That finding notwithstanding, the Referee further found that the "title" "harvest worker, fruit" (DOT 403.687-018, strength requirement "medium"), most reasonably describes claimant's job at injury. Finally, the Referee found that claimant's RFC at the time of the Determination Order was also "medium." Therefore, the Referee assigned an adaptability factor of 1.

On review, claimant asserts that the physical demands of her work at injury were greater than medium. Inasmuch as the adaptability factor is based upon strength demands, we find it reasonable to consider both claimant's job duties and the physical demands of the job she was actually performing at the time of her injury in determining the proper DOT code to be assigned to her job. See William L. Knox, 45 Van Natta 854 (1993) (In determining the proper DOT job description, the Board considers the record as a whole, as it relates to job duties as well as strength demands to find the position which appropriately describes claimant's job at injury). Based on claimant's unrebutted testimony, we find, as did the Referee, that claimant frequently lifted over 50 pounds. The DOT title that most reasonably describes claimant's regular job as a "berry weigher"/"ticket puncher" is "farmworker, general" (DOT 421.687-010). Based on the physical demands of claimant's job at injury, we agree that her prior strength requirement was "heavy."

Claimant further contends that her RFC is sedentary, as opined by Dr. Lee. In a June 9, 1992 "check-the-box" report, Dr. Lee "anticipated" that claimant would be limited to sedentary work. On the other hand, Dr. Bald has permanently restricted claimant from lifting over 50 pounds. We do not find Dr. Lee's conjecture regarding claimant's future RFC to be persuasive, especially in comparison to Dr. Bald's well-reasoned report. See Somers v. SAIF, 77 Or App 259 (1986). We find, therefore, that claimant's RFC is medium. Former OAR 436-35-270(3)(g)(C). Accordingly, claimant is entitled to a value of 3 for adaptability. Former OAR 436-35-310(2).

Impairment

The Referee awarded claimant 5 percent impairment for a chronic condition limiting repetitive use of the low back. In doing so, the Referee relied on the June 9, 1992 report from Dr. Lee. Former OAR 436-35-320(5), provides, in relevant part:

> "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."

Establishment of an unscheduled chronic condition impairment requires medical evidence of at least a partial loss of ability to repetitively use the body area. Glenda R. Linderman, 46 Van Natta 47 (1994).

As with claimant's scheduled chronic impairment, Dr. Lee indicated only that he "anticipate[d] that claimant will have a chronic condition that limits the repetitive use of her low back." For the reasons expressed above, neither do we find that claimant has established entitlement to an unscheduled chronic condition impairment.

Under these circumstances, we instead accept the parties' stipulation that claimant is entitled to an impairment value of 1 percent for loss of thoracolumbar range of motion.

Age/Education

The parties stipulated at hearing that the combined value for claimant's age and education factors is 7.

Former OAR 436-35-280(6) provides that the values for age and education are multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. Former OAR 436-35-280(7).

Applying these rules to the instant case, when the value for the age and education factors (7) is multiplied by the adaptability factor (3), the resulting value is 21. That product is then added to the impairment value (1), resulting in an award of 22 percent unscheduled permanent disability. The Determination Order award is, therefore, reinstated and affirmed.

Offset

The Referee authorized the insurer to offset overpaid PPD against future PPD awarded on this claim. Claimant contends that the law does not allow offset of overpaid "permanent" disability benefits. Inasmuch as we have reinstated the Determination Order's award of 22 percent unscheduled permanent disability, there is no longer an overpayment. Therefore, we do not discuss the issue of "offset."

Attorney fee

We further conclude that, inasmuch as this order increases claimant's unscheduled permanent disability award, claimant's counsel is entitled to an attorney fee payable from the increased compensation. ORS 656.386(2). In awarding an attorney fee, we rely upon our recently issued decision in Jane A. Volk, 46 Van Natta 681 (1994). In Volk, the issue presented was whether an insurer was required to pay an "out-of-compensation" attorney fee award to a claimant's attorney, where the permanent disability award (including the portion which represented the attorney fee award), had already been paid to the claimant. We concluded that the claimant's counsel was entitled to an attorney fee as the attorney was instrumental in establishing the claimant's entitlement to a permanent disability award and had obtained a "substantive increase" in the claimant's permanent disability award.

Similarly, in the present case, we find that claimant's attorney has been instrumental in obtaining an increase in claimant's permanent disability and is entitled to an attorney fee pursuant to ORS 656.386(2). That fee shall be equal to 25 percent of the increased compensation created by this order (10 percent unscheduled permanent disability; 22 percent - 12 percent granted by the Referee's order). OAR 438-15-055(1). In the event that the permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.

Vocational Assistance

Finding that claimant was released to "regular" work, the Director concluded that claimant was ineligible for vocational assistance under OAR 436-120-040(3)(a). 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.

We affirm the Referee's conclusion that claimant is ineligible for vocational assistance, with the following supplementation.

Subsequent to the Referee's order, the Supreme Court in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993), explained the scope of a referee's review of a Director's order. The Court stated 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-J, supra at 537.

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 not released to return to "regular" work, as was found by the Director. Nonetheless, finding that both claimant's job at injury and her RFC are "medium," the Referee concluded that claimant is ineligible for vocational assistance. On review, claimant contends that the Referee should not have affirmed the Director's order as it was based on a finding contrary to the Referee's independent finding that claimant was not released for "regular" work.

After reviewing the record, we agree that claimant was not released to return to "regular" work. However, although the Referee's finding regarding claimant's release to work was contrary to a finding in the Director's order, we conclude that such a disparity, in and of itself, does not provide a basis for modification of the Director's order pursuant to ORS 656.283(2). Moreover, we add the following supplementation.

Under ORS 656.340, a worker is eligible for vocational assistance if the worker cannot return to her prior employment or other suitable employment. Among other things, employment is suitable if it produces 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).

At the time of the compensable injury, claimant was employed as a "berry weigher"/ticket puncher," earning $5.50 per hour. Accordingly, if claimant is unable to return to employment that produces a wage within 20 percent of $5.50 an hour, that is, $4.40 an hour, she has satisfied one of several criteria for establishing eligibility for vocational assistance. However, if claimant is able to return to employment that produces a wage of $4.40 an hour, she is ineligible for vocational assistance. See OAR 436-120-040 (a worker is eligible for vocational assistance only when all the eligibility criteria have been met).

At present, the state and federal minimum wage is $4.75 an hour. See Earl D. Lesperance, 45 Van Natta 2133 (1993). Consequently, using a base wage of $4.40 an hour to calculate suitable employment, claimant would not have a substantial handicap to employment. See ORS 656.340(6)(b)(B)(iii). Because suitable employment is available to claimant at 80 percent of her base wage, we find no basis to modify the Director's order concluding that claimant is not entitled to vocational assistance.

ORDER

The Referee's order dated December 8, 1992 is affirmed in part, modified in part, and reversed in part. In addition to the Referee's award of 12 percent (38.4 degrees) unscheduled permanent partial disability, claimant is awarded 10 percent (32 degrees) for a total award to date of 22 percent (70.4 degrees) unscheduled permanent partial disability. The Referee's offset authorization is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order (10 percent unscheduled permanent disability), not to exceed $3,800.

In the Matter of the Compensation of
PAULETTE J. AYO-WILLIAMS, Claimant
WCB Case No. 93-05632
ORDER ON REVIEW
Gary D. Taylor, Claimant Attorney
Raymond Myers (Saif), Defense Attorney
Vick & Gutzler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Quillinan's order which upheld the SAIF Corporation's denial of a right elbow condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation: Claimant's treating physician, Dr. Stevens, found that claimant's "need to use the crutches and walker for her left heel treatment is the major contributing cause to the right elbow condition." (Ex. 11-1).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's compensable left leg condition was not the major contributing cause of her right elbow condition. We disagree.

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, 113 Or App 411 (1992).

Dr. Stevens, claimant's treating physician, opined that claimant's need to use crutches and a walker for the treatment of her left leg condition is the major contributing cause of her right elbow condition. (Ex. 11-1). However, Dr. Woolpert, a physician who examined claimant for SAIF, concluded that it was more likely that claimant's right elbow condition was attributable to idiopathic tendonitis. (Ex. 10-6).

When there is a dispute between medical experts, we give the most weight to those opinions that are both well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, the medical opinion of the treating physician is generally afforded more weight. Taylor v. SAIF, 75 Or App 583 (1985).

Inasmuch as we find no persuasive reasons to discount the opinion of Dr. Stevens, we defer to his conclusions as the treating physician. We base our reliance on the following reasoning.

Dr. Stephens has treated claimant since the onset of her compensable left leg condition and there is no suggestion that he did not have an accurate history regarding claimant's subsequent right elbow condition. Given his familiarity with claimant's treatment and the progression of her complaints, we consider Dr. Stevens' observations to be particularly persuasive.

Dr. Stevens attributes the onset of claimant's right elbow condition to the use of crutches and a walker necessary to the treatment of her previously accepted left leg conditions. (Ex. 6-9). Dr. Stephens expressly finds the crutches and walker to be the major contributing cause of the right elbow condition. (Exs. 9-1, 11-1).

Dr. Woolpert's opinion is less persuasive. He bases his medical opinion primarily on two observations, but only one of them is uncontroverted. He correctly relates the time discrepancy of six months between when claimant discontinued use of the walker, (Tr. 5), and when she first mentioned her right elbow condition. (Ex. 6-9).

However, immediately prior to this observation, Dr. Woolpert contradicts claimant's recollection of her symptoms after she ceased using the walker. Dr. Woolpert states: "if indeed it was caused by walker use for a two week period of time, one would certainly anticipate with discontinuation of the walker that the patient should have improved rather than become worse." (Ex. 10-5). Claimant testified that her right elbow symptoms did in fact diminish significantly upon discontinuing use of the walker. (Tr. 6-7).

The Referee found Dr. Stevens' opinion on causation to be less persuasive due to an absence of evidence that claimant used crutches for a significant period of time after she discontinued using the walker. (O&O at 2). Our reading of Dr. Stevens' opinion does not cause us to conclude that Dr. Stevens' opinion was premised on the assumption that claimant's use of crutches was significant. Rather, we interpret Dr. Stevens' opinion to be that claimant's use of a walker and crutches (whether or not that use was significant) was the major contributor to claimant's right elbow condition.

Consequently, there are no persuasive reasons not to defer to the opinion of claimant's treating physician. Based on Dr. Stevens' conclusion, we hold that the major contributing cause of claimant's right elbow condition was the use of crutches and a walker during the rehabilitation of her compensable left leg condition. ORS 656.005(7)(a)(A).

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

ORDER

The Referee's order dated August 11, 1993 is reversed. The SAIF's Corporation's denial is set aside and the claim remanded to the SAIF for processing according to law. Claimant's attorney is awarded $3,000 for services at hearing and on review, to be paid by SAIF.

May 6, 1994 Cite as 46 Van Natta 871 (1994)

In the Matter of the Compensation of
MICHAEL S. BLAND, Claimant
WCB Case No. 93-04055
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Brown's order which dismissed claimant's hearing request seeking a penalty pursuant to ORS 656.268(4)(g) under an Order on Reconsideration which had become final by operation of law. On review, the issue is dismissal.

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

Claimant's claim for a right hand and forearm injury was closed by Notice of Closure on June 25, 1992, awarding claimant 4 percent (6 degrees) scheduled permanent disability for the right forearm. A March 8, 1993 Order on Reconsideration increased claimant's scheduled award to a total of 20 percent (30 degrees).[1] The reconsideration order did not assess a penalty pursuant to ORS 656.268(4)(g) for the increased award.

On April 3, 1993, claimant requested a hearing seeking a 25 percent penalty under ORS 656.268(4)(g) for the increased permanent disability award granted by the reconsideration order. The parties stipulated that claimant's hearing request regarding the Determination Order and Order on Reconsideration was not within the statutory time limitation under ORS 656.268(6)(b).

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[1] The employer argued that, on reconsideration, before a penalty is warranted, an additional 20 percent permanent disability must be awarded, and that additional 20 percent must be a 25 percent increase over the previous award. We do not agree and consider this argument contrary to the plain meaning of the statute. See Nero v. City of Tualatin, 127 Or App 458 (1994).

The Referee concluded that ORS 656.268(4)(g) provides that the time for assessment of a penalty is upon reconsideration. Therefore, because claimant objected to the reconsideration order failing to assess the penalty, claimant was required to request a hearing within 180 days after the notice of closure was mailed (less the time of the reconsideration). See ORS 656.268(6)(b). Thus, finding the hearing request untimely, the Referee dismissed claimant's request for hearing. We agree with the Referee.

Claimant argues that the assessment of a penalty pursuant to ORS 656.268(4)(g) is mandatory, not discretionary. Therefore, claimant reasons that it is not necessary to request a hearing challenging the reconsideration order in order to be awarded the penalty. Claimant contends that this is particularly true where, as here, he is not objecting to the increased permanent disability award.

ORS 656.268(6)(b) specifically states that, if a party objects to a reconsideration order, the party may request a hearing within 180 days after copies of the notice of closure or determination order are mailed. Here, claimant disagreed with the reconsideration order in that it had not assessed a 25 percent penalty when claimant was found to be 20 percent permanently disabled. Thus, claimant's remedy, as provided by statute, was to request a hearing within 180 days of the mailing of the Notice of Closure (not including the time of reconsideration).

The Court of Appeals, in Nelson v. SAIF, 43 Or App 155, 159 (1979), stated in part:

> "The benefits awarded under the workers' compensation law are purely statutory, and a claimant must strictly follow the prescribed procedures in order to recover under the law. Gerber v. State Ind. Acc. Com., 164 Or 353, (1940). Time limitations prescribed by law are limitations upon the right to obtain compensation and are not subject to exceptions contained within the general statute of limitations. Lough v. State Industrial Acc. Com., 104 Or 313 (1922). Neither the Board nor the courts may waive these requirements. Johnson v. Compensation Department, 246 Or 449, (1967); Rosell v. State Ind. Acc. Com., 164 Or 173 (1940)."

Accordingly, in light of the above, because claimant did not comply with the statutory requirement for contesting a reconsideration order, we agree that the Referee properly dismissed claimant's hearing request.[2]

The Referee alternatively concluded that claimant would not be entitled to a penalty pursuant to ORS 656.268(4)(g) even if he had filed a timely hearing request. The Referee reasoned that, pursuant to OAR 436-30-050(13), 20 percent disability equals 64 degrees. In light of the fact that claimant's 20 percent scheduled disability would total only 30 degrees for a forearm, the Referee concluded that the penalty statute was not applicable in this case. We disagree.

Subsequent to the Referee's order, we have reasoned that OAR 436-30-050(13) is not consistent with the unambiguous language of ORS 656.268(4)(g), which expressly applies to claimants who are found to be "at least 20 percent permanently disabled." Accordingly, we have declined to interpret OAR 436-30-050(13) as a bar to the assessment of a penalty pursuant to the terms of ORS 656.268(4)(g) when the total award calculates to less than 64 degrees. See Steven L. Cline, 46 Van Natta 512 (1994).

ORDER

The Referee's order dated July 16, 1993 is affirmed.

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[2] Under the facts of this case, we agree that a penalty is mandatory. However, we also agree that we must look to the statutory context in which the penalty provision is located in order to determine what, if any, time limits apply. Here, because the penalty provision is located in the same section of the statute (albeit in a different subsection) as the 180 day hearing request limitation, we are required to follow the statutory limitation.

In the Matter of the Compensation of
GERALD H. COULSEY, Claimant
WCB Case No. 93-07563
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Davis' order that dismissed his request for hearing on the basis that it was not timely filed. On review, the issue is jurisdiction.

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

A Notice of Closure was first mailed on October 30, 1992. A second Notice of Closure was mailed on December 4, 1992 correcting the original Notice of Closure. Claimant challenges the Referee's conclusions that claimant's appeal rights ran from the first, rather than corrected, Notice of Closure and, because the request for hearing was not filed within 180 days of the mailing date of the original Notice of Closure, his request for hearing was not timely filed.

Along with affirming the Referee's order, we find alternative reasons for finding that claimant's request for hearing was properly dismissed. A party objecting to an Order on Reconsideration must file a request for hearing within 180 days of the mailing date of a closure order. ORS 656.268(6)(b), 656.319(4). The time between the request for reconsideration and issuance of the Order on Reconsideration is not counted in the 180-day period for filing a request for hearing. ORS 656.268(6)(b).

Here, claimant filed the request for reconsideration on June 2, 1993. Therefore, even if the 180-day period began on December 4, 1992, as claimant asserts, 179 days had already passed by the time he filed his request for reconsideration. On June 21, 1993, an Order Denying Reconsideration issued. Thus, claimant was required to file his request for hearing by June 22, 1993. However, claimant's request for hearing was received on June 28, 1993, and, therefore, was not "filed" until that date. See OAR 438-05-046(1)(b).

Consequently, even based on the mailing date of the corrected Notice of Closure, claimant's request for hearing was not timely filed.

ORDER

The Referee's order dated September 14, 1993 is affirmed.

In the Matter of the Compensation of
MARK A. CRAWFORD, Claimant
WCB Case No. 91-03109
ORDER ON RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

The self-insured employer requests reconsideration of that portion of our April 14, 1994 Order on Review in which we noted that the parties' May 18, 1993 Stipulation that amended a January 27, 1993 Order on Reconsideration was a final judgment that prevented either party from challenging claimant's substantive entitlement to temporary disability benefits.

The January 27, 1993 Order on Reconsideration incorporated a July 1, 1992 Opinion and Order, reconsidered September 25, 1992, that addressed claimant's procedural entitlement to temporary disability benefits, to establish claimant's substantive entitlement to temporary disability benefits.

On reconsideration, the employer argues that it could not have appealed the Order on Reconsideration's award of substantive temporary disability, because claimant's entitlement to procedural temporary disability was on Board review. Although this argument is not directly germane to the issue on review, we disagree with the employer's contention and write to clarify our analysis.

Prior to claim closure, only claimant's procedural entitlement to temporary disability benefits, a claim processing matter, can be at issue. SAIF v. Taylor, 126 Or App 658, 660 (1994); see also Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Therefore, since claimant's claim had not been closed, the issue before Referee Mongrain, which is the issue on review, was claimant's procedural entitlement to temporary disability benefits.

In contrast, a claimant's entitlement to substantive temporary disability compensation, which is based on different criteria from entitlement to procedural temporary disability compensation, is established at the time of claim closure. Id.

Although an employer is not required to seek review of a Determination Order or, by extension, an Order on Reconsideration during the pendency of an appeal of the compensability of a claim in order to stay compensation under ORS 656.313[1], if an employer disagrees with an award made by an Order on Reconsideration, it is necessary to appeal it. See ORS 656.268(6)(b); Diamond Fruit Growers v. Goss, 120 Or App 390 (1993); Felipe A. Rocha, 45 Van Natta 47 (1993).

Here, the employer requested a hearing on the Order on Reconsideration pursuant to ORS 656.268(6)(b). However, rather than proceed to hearing, the parties settled all issues raised or which could have been raised by a May 18, 1993 Stipulation. This stipulation is a final judgment that settled the substantive temporary disability matter. See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). Thus, the parties are precluded from contesting the amounts awarded by that order as amended by the stipulation. See Drews v. EBI, 310 Or 134 (1990).

Had the employer proceeded to a hearing on the Order on Reconsideration, it could have argued that the Order on Reconsideration wrongly relied on an order that addressed procedural temporary disability, a claims processing matter, to establish claimant's entitlement to substantive temporary disability. Alternatively, the employer could have requested a postponement of the hearing until the procedural temporary disability issue in this case was finally decided. The employer chose to do neither.

Accordingly, our April 14, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 14, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Neither the compensability of the claim nor the stay of compensation were matters before us.

May 6, 1994 Cite as 46 Van Natta 874 (1994)

In the Matter of the Compensation of
MARCIA CROW, Claimant
WCB Case No. 92-16400
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Crumme's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

The Referee determined that, because claimant's work for both Liberty's insured and SAIF's insured potentially contributed to her carpal tunnel syndrome, claimant could rely on the last injurious exposure rule to establish compensability. We disagree.

Claimant worked concurrently for Liberty's and SAIF's insureds. She worked from July 1987 to the present for Liberty's insured. This work involved assembling rifle scopes and material handling. Claimant worked for SAIF's insured from April 1991 to November 1992 performing janitorial work.

Claimant first sought treatment for her carpal tunnel syndrome on September 24, 1992 and filed a claim with Liberty's insured.

Liberty subsequently issued a compensability denial and a disclaimer of responsibility, which asserted that SAIF's insured was potentially liable for her claim. At hearing, claimant withdrew her request for hearing against SAIF when Liberty withdrew its responsibility denial. At issue was whether claimant's work activities for Liberty's insured were the major contributing cause of her bilateral carpal tunnel syndrome. Because responsibility was not at issue, even assuming, without deciding, that claimant's employment was concurrent, the last injurious exposure rule is inapplicable. Colwell v. Trotman, 47 Or App 855 (1980); cf. Tina R. Flansberg, 44 Van Natta 2380 (1992) on recon 45 Van Natta 1031 (1993).

Accordingly, to establish a compensable occupational disease, claimant must prove that her employment conditions, compared to nonwork conditions, were the major contributing cause of or worsening of her bilateral carpal tunnel syndrome. ORS 656.802(2). Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. Weller v. Union Carbide, 288 Or 27 (1979).

We agree with and adopt the Referee's analysis and conclusion that the opinions of Drs. Ushman and Martens are persuasive. Their opinions establish that claimant's assembly work for Liberty's insured involved repetitive motion and that this work, rather than claimant's obesity, was the major contributing cause of her carpal tunnel syndrome. In addition, Dr. Ushman explains the basis for his disagreement with Dr. Nathan's opinion, and he affirmatively opines that claimant's work exposure with Liberty's insured was the major contributing cause of her carpal tunnel syndrome. ESCO Corporation v. Manley, 83 Or App 406 (1987).

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

ORDER

The Referee's order dated July 8, 1993 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by Liberty.

May 6, 1994 Cite as 46 Van Natta 875 (1994)

In the Matter of the Compensation of
ROSE L. DIXON, Claimant
WCB Case No. 93-03057
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

On April 13, 1994, we issued an Order on Review that: (1) affirmed that portion of the Referee's order which awarded 5 percent scheduled permanent disability for the right wrist; and (2) reversed that portion of the Referee's order which declined to authorize an offset. Noting that the parties have agreed to settle their dispute, the self-insured employer seeks abatement of our order to await their written argument.

In light of this unrebutted announcement, we withdraw our April 13, 1994 order. On receipt of the proposed agreement, we shall proceed with our review of the settlement. In the meantime, the parties are requested to keep us apprised of any further developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROGER D. JOBE, Claimant
WCB Case Nos. 92-15112 & 92-10152
ORDER ON REVIEW
Gary D. Taylor, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation, on behalf of R. Keith Foster, a noncomplying employer, requests review of those portions of Referee Nichols' order that: (1) set aside SAIF's partial denial of compensability for claimant's current neck condition and headaches; (2) found SAIF responsible for claimant's current low back condition; and (3) awarded an assessed fee to be paid by SAIF. On review, the issues are compensability, responsibility and attorney fees. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in 1981 while working for a noncomplying employer. SAIF accepted a disabling low back strain. The claim was closed in February 1982 with an award of time loss only.

Claimant continued to have low back and right leg pain. The claim was reopened and reclosed numerous times. Dr. Kendrick performed an L5-S1 diskectomy in 1984. In 1985, claimant began experiencing muscle spasms in his upper back and neck, muscular contraction headaches, and low back muscle spasms radiating into both legs, with pain in the right leg. In 1987, Drs. Sulkosky and Kendrick performed an L5-S1 fusion. In October 1987, SAIF closed the claim with an award of 20 percent unscheduled permanent disability.

After the second surgery, claimant experienced giveway in the right leg that resulted in falls. After an April 1988 fall, claimant experienced neck pain and increasing headaches. In 1988 and 1989, claimant continued to have complaints of low back pain, leg giveway and headaches. SAIF reopened the claim in December 1988 for low back pain. Claimant became medically stationary in April 1989 and SAIF reclosed the claim on January 25, 1990.

Claimant went to work for Logan International, Liberty Northwest's insured, on September 10, 1989. (Ex. 71).

Claimant did not receive treatment for his complaints from November 1989 until October 1990, when he again sought treatment for chronic low back pain that had been increasing for the prior month, as well as pain and numbness in the right leg. (Ex. 72).

On November 29, 1990, a pallet of empty cartons fell on claimant's right side, causing him to fall to the ground on his left. Claimant experienced acute pain in his right leg, low back, shoulders and neck. Liberty Northwest accepted a low back strain/soft tissue injury. Claimant continued to have tension headaches and leg giveway that resulted in falls. As a result of the falls, claimant sometimes struck his head. (Exs. 81 and 91).

On June 3, 1991, Dr. Kendrick recommended a pain clinic program for claimant's chronic pain syndrome. Dr. Holmes and others at the Oregon Pain Center evaluated claimant and recommended admission to the full pain treatment program. (Ex. 99). Liberty Northwest denied authorization. (Ex. 103A). Claimant requested a hearing (Ex. 109A), but later withdrew the request and applied for a ruling by the Medical Director after Liberty informed him that the question was the reasonableness and necessity of the recommended treatment plan. (Ex. 111A). On October 13, 1992, the Director dismissed claimant's request for lack of jurisdiction over Liberty's denial of compensability. (Ex. 151).

On February 23, 1992, Dr. Maloney released claimant to modified work. Claimant was unable to return to the modified job because of his episodes of falling and injuring himself. (Exs. 112, 116, 117 and 124). Dr. Maloney had claimant re-evaluated by Dr. Holmes and others at the pain center. Claimant began pain center treatment on April 13, 1992 and completed the program on June 9, 1992. (Exs. 124, 127 and 131).

On June 18, 1992, Liberty Northwest denied payment of the pain center treatment on the basis that it was not authorized. (Ex. 132A). On July 24, 1992, Liberty partially denied claimant's low back complaints, chronic back and right leg pain and chronic headaches and neck pain on the basis that these conditions were not related to the accepted November 1990 back strain injury. (Ex. 146). On August 12, 1992, Liberty closed the claim, finding claimant medically stationary on June 9, 1992, and awarding temporary disability through that date only. (Ex. 148). On August 8, 1992, Liberty notified claimant of an overpayment of temporary disability from June 10, 1992 to July 24, 1992. (Ex. 150).

On October 13, 1992, SAIF disclaimed responsibility for claimant's low back strain/sprain (Ex. 152), and on October 29, 1992, SAIF partially denied a herniated disc at C5-6 and headaches as unrelated to the accepted 1981 injury. (Ex. 153).

On December 21, 1992, the Board issued an Own Motion Order referring SAIF's submission of claimant's request for temporary disability compensation to a consolidated hearing regarding the compensability of claimant's current need for medical treatment. (Ex. 154).

CONCLUSIONS OF LAW AND OPINION

The Referee held SAIF responsible for claimant's current condition, including his low back, headaches and neck complaints, as resulting from its accepted 1981 low back claim. SAIF contends that responsibility shifted to Liberty Northwest pursuant to ORS 656.308(1) because claimant experienced a new compensable injury to his low back at Liberty Northwest's insured. SAIF also contends that, pursuant to ORS 656.005(7)(a)(A), the 1981 injury is not the major contributing cause of claimant's headaches and neck condition, and, if the current neck condition is compensable, it is the responsibility of Liberty as part of the 1990 injury. Liberty argues that claimant's accepted 1990 low back injury resolved; therefore, it argues, the need for continuing treatment is the responsibility of SAIF.

Compensability of Headaches and Neck Condition

We affirm the Referee's opinion on this issue with the following supplementation.

ORS 656.005(7)(a)(A) provides, in part:

> "No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

Under ORS 656.005(7)(a)(A), if a condition or need for treatment is caused by the compensable injury, as opposed to the industrial accident, the major contributing cause standard is applicable. Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant suffered a compensable low back injury in 1981, which SAIF accepted for a noncomplying employer. In 1985, after claimant had a diskectomy at L5-S1, he began experiencing muscle spasms in his upper back and neck, muscular contraction headaches, and low back muscle spasm radiating into both legs, with pain in the right leg. After fusion surgery was performed in 1987, claimant continued to experience low back and leg pain and muscular spasms, which caused him to fall. The claim was closed with an award of temporary and permanent disability. Claimant continued to experience the same low back, leg, neck and headache symptoms. While employed by a different employer in 1988, claimant fell from a ladder as a result of a low back muscle spasm and hurt his neck. Dr. Kendrick opined that claimant had developed a chronic pain syndrome, and that the fall was caused by claimant's pain. Dr. Altrocchi opined that the 1981 injury was the cause of all of claimant's problems, which included headaches; back spasms; a painful neck, i.e., a cervical strain; and leg give-way.

Based on the aforementioned medical evidence, we find that the accepted 1981 injury with SAIF was the major contributing cause of claimant's chronic pain syndrome (headaches, neck pain, and back and leg spasms). Accordingly, claimant's chronic pain syndrome is a compensable consequence of the 1981 injury. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

We note that, although the compensability issue at hearing was framed as a "neck condition," SAIF specifically denied claimant's C5-6 herniated disc, which was initially diagnosed on October 31,

1991. Claimant complained of arm and hand involvement. However, his EMG was normal and claimant had no radicular symptoms, weakness or sensory loss related to the disc. (Ex. 108). There is no medical opinion regarding causation of this disc condition. Consequently, claimant has failed to prove that this disc is a compensable consequence of his 1981 injury. ORS 656.266.

Responsibility

The Referee assigned responsibility for claimant's current condition and need for treatment to SAIF. We affirm, with the following supplementation.

SAIF and claimant each contend that ORS 656.308(1) applies to shift responsibility for all further compensable medical services and disability to Liberty Northwest, a subsequent insurer with an accepted claim, and that responsibility cannot shift back to SAIF. We disagree.

ORS 656.308(1) applies only if it is determined that the "further" disability or treatment for which benefits are sought is compensable, and that it involves a condition that has previously been processed as a part of a compensable claim, in which case responsibility is then assigned to the insurer with the most recent accepted claim for the condition. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). Subsequent to the Referee's order, the Supreme Court addressed the applicability of ORS 656.005(7)(a)(B) to responsibility. See SAIF v. Drews, 318 Or 1 (1993). The Court held 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 only if the new injury is found to be the major contributing cause of the disability or need for treatment. Conversely, if the new injury is not the major contributing cause, responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" pursuant to ORS 656.308(1).

Consequently, the first step in our analysis is to ascertain whether claimant's accidental injury at Liberty Northwest's insured combined with the preexisting condition for which SAIF is responsible. We conclude that it did. Dr. Holmes evaluated claimant on July 18, 1991 and again on March 31, 1992. He stated, "[Claimant's] injury represented a reaggravation of his pre-existing lumbar condition, a result of an original SAIF injury in 1981."

Nevertheless, responsibility for claimant's subsequent disability and need for medical services shifted to Liberty Northwest only if the 1990 injury was the major contributing cause of the chronic pain syndrome and the resulting disability and need for treatment. See Drews, supra.

On April 29, 1991, Drs. Fuller, Andersen and Fabricius concluded that claimant's current symptoms were residuals of the old back fusion and nerve damage, complicated by psychogenic magnification of symptoms. They identified no new pathology. (Ex. 93-5). Dr. Lieuallen concurred in this report. In both of Dr. Holmes' reports, he opined that, although the 1990 injury caused new conditions that needed treatment, namely a lumbar strain and right sacroiliac subluxation, the major contributing cause of claimant's current need for treatment was his 1981 SAIF injury. (Exs. 103-2 and 124-1).

Additional weight to this view is provided by the well-reasoned opinions of Drs. Brooks, neurosurgeon, and Keist, orthopedist, who also attributed claimant's current chronic pain condition to the 1981 injury. See Somers v. SAIF, 77 Or App 259 (1986). They found that, although claimant experienced a transient worsening of chronic pain symptoms due to the accepted 1990 injury, the only diagnosis related to the 1990 injury was a soft tissue injury, which had healed. They opined that claimant's current condition and need for treatment were solely related to his 1981 injury. (Ex. 137). This opinion was initially concurred in by Drs. Kendrick, Maloney and Lieuallen, who had treated claimant subsequent to the 1990 injury. (Exs. 138, 143 and 147). Although Dr. Kendrick later changed his opinion, as expressed in Exhibit 153A, he modified that changed opinion to opine that the 1990 injury was a material contributing cause but not the major contributing cause of claimant's current need for treatment for his low back. (Ex. 155.)

Inasmuch as we do not find the 1990 injury with Liberty Northwest to be the major contributing cause of claimant's current need for treatment and disability, we conclude that SAIF is responsible for the chronic pain syndrome and the resulting disability and need for treatment. See Drews, supra.

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

ORDER

The Referee's order dated February 25, 1993 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the SAIF Corporation.

May 6, 1994 Cite as 46 Van Natta 879 (1994)

In the Matter of the Compensation of
THOMAS E. JOHNSTON, Claimant
WCB Case Nos. 92-06869, 92-06868, 91-15014, 92-03321 & 92-09254
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys
John Motley (Saif), Defense Attorney

Claimant requested reconsideration of our March 7, 1994 Order on Review. On April 5, 1994, we abated the order to consider the motion for reconsideration and granted an opportunity for the insurers to respond. Having received the insurers' timely responses, as well as claimant's reply, we proceed with our reconsideration.

In our original order, we addressed whether claimant had established compensability of a cervical condition. After addressing numerous opinions regarding causation, we found that the panel of Drs. Brook and Coletti, which examined claimant on behalf of SAIF, provided the most persuasive opinion because it was based on an accurate history regarding the onset of claimant's neck symptoms. Because this opinion indicated that claimant's cervical condition was not related to a work injury or work activity, we found that claimant failed to prove compensability. See ORS 656.802(2); ORS 656.005(7)(a)(B).

Claimant objects to our evaluation of the medical opinions. In particular, claimant challenges our statement that the opinion of Drs. Brook and Coletti was based on an accurate history "insofar as it indicated that the onset of claimant's neck symptoms was after he stopped working at Mt. Mazama Plywood and Emerald Forest Products." Claimant asserts that this statement reflects a "superficial if not careless reading of the medical record" based on medical evidence that claimant sought treatment in 1983 for neck symptoms.

We disagree with claimant's contention that we overlooked or ignored claimant's 1983 treatment for neck symptoms. In our prior order, we noted that claimant complained of neck discomfort in 1983 and received treatment for such symptoms. Moreover, our order contains citations to the same exhibits upon which claimant relies in his memorandum. Finally, in the opinion portion of our order we refer to the "evidence that claimant experienced some neck symptoms in 1983."

Furthermore, we disagree with claimant's assertion that Drs. Brooks and Coletti failed to consider the 1983 treatment. Their report noted claimant's statement that "he started having [neck] problems while he was working at Mt. Mazama" and that the 827 form for the 1983 injury indicated that he injured his right arm up to the neck. (Ex. 108-3).

More importantly, Drs. Brooks and Coletti provided the only opinion that was based on a history that, after resolving, claimant's neck symptoms did not begin again until after he stopped working. As explained in our order, based on inconsistencies with the record, we found unreliable claimant's testimony that his neck pain began with a 1983 injury and, after decreasing for a short time, progressively worsened. Instead, based on the record, we found that, after experiencing some neck symptoms in 1983, his symptoms shortly thereafter resolved, and he did not complain again about neck pain until July 1988.

Because the remaining opinions were not based on this history, we found them unpersuasive. Therefore, even if we agreed with claimant that the opinion of Drs. Brooks and Coletti did not account for the 1983 neck treatment, we would continue to find that he did not carry his burden of proof because he provided no opinion that was based on an accurate history of his neck symptoms.

However, we wish to correct one portion of the order which mistakenly referred to Dr. McKillop when discussing Dr. Karasek's opinion. In place of the discussion on page 5 of the order, we provide the following:

> "We also find that Dr. Karasek's opinion is not persuasive. Like Dr. Hacker, it appears that Dr. Karasek based his opinion on claimant's inaccurate reporting of his history rather than the medical record. (See Ex. 76). Furthermore, Dr. Karasek's opinion regarding causation is not consistent. Dr. Karasek first indicated that work activities, and not claimant's prior compensable 1986 shoulder condition, caused his cervical condition. However, he later concurred with a letter stating that the cervical condition was "causally related" to the 1986 shoulder condition. Thus, having found that Dr. Karasek's opinion is based on an inaccurate history and not well-reasoned, we also find it unpersuasive and give it little weight. See Somers v. SAIF, supra.
>
> "Because Dr. McKillop indicated that claimant's neck symptoms began in 1986, and such a history is not supported by the medical record, we also find that Dr. McKillop's opinion is based on an inaccurate history and, therefore, not reliable. See Somers v. SAIF, supra."

This clarification also responds to claimant's contention that the Board's order failed to assess the persuasiveness of Dr. Karasek's opinion and, specifically, his assertion that Dr. Karasek provided the most reliable opinion.

In its response, Liberty contests that portion of our prior order finding it responsible for claimant's psychological condition. For the reasons expressed in our prior order, we continue to adhere to this conclusion.

On reconsideration, as supplemented herein, we adhere to and republish our March 7, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 6, 1994 Cite as 46 Van Natta 880 (1994)

In the Matter of the Complying Status of
TIM AND TERRY JONES, dba ACE TREE COMPANY, Noncomplying Employer
WCB Case No. 93-07172
ORDER OF DISMISSAL
Michael B. Dye, Attorney
Roberts, et al., Attorneys

Timothy and Terry Jones dba Ace Tree Company, an alleged noncomplying employer, requests Board review of Referee Lipton's order which: (1) affirmed the Department's June 2, 1993 order finding the Joneses to be a noncomplying employer; and (2) awarded claimant an assessed attorney fee, payable by the Joneses. We dismiss for lack of jurisdiction.

The Joneses requested a hearing concerning the Department's order which found them to be a noncomplying employer. At hearing, the Joneses contended that the Department's noncomplying employer order was precluded by a prior proceeding and the ultimate dismissal of that proceeding, which also involved the Joneses' status as a noncomplying employer. No other issues were raised at hearing, other than the Department's order. The Referee affirmed the Department's order. The Referee's order contained a statement indicating that review of his order was to the Board. The Joneses timely requested Board review.

A threshold issue not raised by the parties is whether we have jurisdiction for review. Subject matter jurisdiction may be addressed by the Board at anytime in the course of litigation, whether or not raised by the parties. See Schlecht v. SAIF, 60 Or App 449, 451 (1982).

An alleged noncomplying employer may contest the Department's order of noncompliance by filing a request for hearing with the Department pursuant to ORS 656.740. The order of the referee is deemed to be a final order of the Director. ORS 656.740(1) and (3). Jurisdiction for review of the referee's order is as provided in ORS 656.740(4).

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 concerning the Department's noncomplying employer order. Elias S. Jones, 45 Van Natta 1691 (1993).

Here, the Joneses only requested a hearing regarding the Department's June 2, 1993 noncomplying employer (NCE) order. The Joneses did not object to the Department's findings and conclusion that they were a noncomplying employer, but rather contended that the June 2, 1993 NCE order was without any legal effect given the Department's prior rescission of a February 1, 1989 NCE order and a subsequent dismissal of the hearing request protesting that order. Although the Joneses described their challenge to the June 1993 NCE order on legal rather than factual grounds, the issue was still encompassed within the Referee's review of the Department's NCE order, which concerned only the status of the employer and did not involve any "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; Jesus Fletes, et al, 45 Van Natta 2252, on recon 45 Van Natta 2376 (1993).

In reaching our conclusion, we recognize that the Referee's order contained an incorrect statement regarding the parties' rights of appeal. Notwithstanding this unfortunate oversight, since our jurisdiction is limited, an incorrect statement of appeal rights can neither expand nor contract our statutory authority. Elias S. Jones, supra; see Larry J. Powell, 42 Van Natta 1594 (1990); Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MAXINE C. KOSKI, Claimant
WCB Case No. 93-06629
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of those portions of Referee Daughtry's order which: (1) set aside SAIF's alleged "de facto" denial of claimant's low back and left sacroiliac strains; and (2) awarded claimant an assessed attorney fee pursuant to ORS 656.386(1) for prevailing over SAIF's "de facto" denial. On review, the issues are "de facto" denial and attorney fees.

We adopt and affirm the Referee's order.[1] See Wesley R. Craddock, 46 Van Natta 713 (1994) (Where SAIF's written acceptance was specifically limited to listed conditions, Board found a "de facto" denial existed regarding other claimed conditions.).

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 "de facto" denial issue is $299, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In addition, we have considered that claimant is not entitled to an attorney fee award for services on review concerning the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 29, 1993 is affirmed. Claimant's attorney is awarded $299 for services on Board review, to be paid by the SAIF Corporation.

[1] As was the Referee, we are also astonished that claimant's attorney did not contact SAIF directly prior to filing a hearing request. Such an action would likely have resolved this matter, thus avoiding litigation in furtherance of the goals set forth in ORS 656.012(2)(b).

In the Matter of the Compensation of
JUDITH M. MORLEY, Claimant
WCB Case No. 92-15147
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Baker's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for a left wrist/forearm condition; and (2) declined to assess penalties and attorney fees for the insurer'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

Preliminary Issue

Before proceeding with the merits of this claim, we first address a preliminary issue raised on review by claimant. The insurer denied claimant's left wrist/forearm condition on the ground that the

claim was untimely filed. (Ex. 35). Claimant argues that, under Tattoo v. Barrett Business Service, 118 Or App 348 (1993), the insurer is precluded from contesting the merits of claimant's current claim. In Tattoo, the court held that employers are bound by the express language of their denials. Id. at 351-52.

Here, the insurer denied claimant's left wrist/forearm condition solely for failure to timely file a claim. (See Ex. 35). Neither the insurer nor claimant, however, offered testimony or any other evidence regarding the meaning of the insurer's denial.

Although it was not a subject of the insurer's denial, both parties litigated the compensability of claimant's left wrist/forearm condition.[1] The Court of Appeals has held that parties to a workers' compensation proceeding may, by agreement, try an issue that falls outside the express terms of a denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990); see also Charles M. Anderson, 43 Van Natta 463 (1991). Because the parties tried the compensability issue by implicit agreement (that is, without objection), we conclude that the issue was properly before the Referee.[2] We turn to the merits of the case.

Compensability

The Referee concluded that the insurer properly denied claimant's left wrist/forearm condition because claimant's symptoms did not require medical services or result in disability sufficient to support a claim for compensation. We agree with the Referee's conclusion, but offer the following analysis.

The Referee stated that the principal issue at hearing was the compensability of claimant's occupational disease claim for her left wrist/forearm condition. Because the evidence reveals that claimant's left wrist/forearm condition had a gradual onset, we agree that the claim properly is an occupational disease claim. See Valtinson v. SAIF, 56 Or App 186 (1982).

An "occupational disease" is any disease or infection arising out of and in the course of employment that requires medical services or results in disability or death. ORS 656.802(1). To prevail on an occupational disease theory, claimant must establish that her employment conditions were the major contributing cause of her left wrist/forearm condition. ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145 (1983); Enid S. Crowe, 45 Van Natta 1718 (1993).

The insurer argues that, because claimant's left wrist/forearm condition required no medical services and did not result in disability, claimant's claim fails. We need not address that issue, because we conclude that claimant has failed to meet her burden of proof under ORS 656.802(2).[3]

Two medical experts address the cause of claimant's left wrist/forearm condition: Dr. Lawton, claimant's treating physician, and Dr. Nathan, the insurer's examining physician.

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[1] The entire hearing focused on the nature of claimant's work responsibilities and her medical condition. During closing arguments, claimant's counsel identified the issues as compensability and penalties and attorney fees. (Ex. 37-14). He then referred to medical reports from claimant's treating physician as support for the compensability of claimant's condition. (Id. at 15).

[2] The insurer's denial also expressly stated that it was not waiving any further questions regarding compensability. (Ex. 35). Because we have concluded that the parties agreed to litigate the compensability of claimant's current condition, we need not, and do not, address what impact, if any, the insurer's express refusal to waive further questions of compensability might have had on the analysis.

[3] Although we do not address the medical treatment issue, we note a misstatement in claimant's appellate brief with respect to that issue. Claimant states that she "specifically agrees with the Referee's statement of fact that claimant received treatment for the left side on November 20, 1990 (O&O p. 2)." Claimant's Appellant Brief at 1. The Referee made no such finding. The Referee found that "[t]he first medical reference to any left arm/hand problem was November 20, 1990 * * *." Opinion and Order at 2.

On October 25, 1990, during the course of rendering a report regarding claimant's right arm condition (which is not a part of this case), Dr. Lawton reported that claimant was not aware of any unusual activity or cause of her right arm symptoms that may have occurred off the job or at home. (Id).

Dr. Nathan examined claimant on January 23, 1991 and February 6, 1991, after the onset of claimant's left arm symptoms. (Ex. 11-1). Dr. Nathan's report includes a description of claimant's work duties. However, it does not reveal whether Nathan considered any other possible non-work causes of claimant's condition.

On the basis of claimant's history and examination, and negative nerve conduction studies and x-rays, Dr. Nathan diagnosed "[d]iscomfort, peripheral nerves, both upper extremities." (Id. at 5). He then concluded that "there does appear to be a relationship between [claimant's] symptoms and her work activities, but in the absence of confirmatory diagnoses, it is difficult to state whether her work was responsible for the development or aggravation of an underlying condition." (Id. at 6).[4]

On March 5, 1991, Dr. Lawton generally concurred with Dr. Nathan's report. (Ex. 15).

On May 22 1991, after reviewing Dr. Lawton's reports, Dr. Nathan adhered to his opinion that claimant's symptoms were related to her work activities, but that it did not appear that her work produced or aggravated any identifiable underlying pathology. (Ex. 18).

On December 1, 1992, Dr. Lawton reported that, on November 20, 1990, claimant had first mentioned her left arm symptoms, which claimant felt were related to her having worked six days in a row and having shifted some of her work duties to her left side. (Ex. 36). Dr. Lawton stated, "It is felt that [claimant's] complaint of similar tenderness and soreness over the radial wrist extensor in the left arm was likely related to her work particularly the six day stint." (Id). The report does not reveal whether Dr. Lawton considered any other possible causes of claimant's left wrist/ forearm condition.

We conclude that the evidence does not satisfy claimant's burden of proof. Although "magic words" are not necessary, McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), we conclude that the record, taken as a whole, fails to establish that claimant's work exposure was the major contributing cause of her left wrist/forearm condition.

We find both Drs. Lawton's and Nathan's opinions flawed because there is no indication that they considered other possible causes of claimant's left wrist/forearm condition. See, e.g., Somers v. SAIF, 77 Or App 259 (1986); Luella M. Best, 45 Van Natta 1638 (1993). Dr. Nathan's reports are silent regarding that issue, while the only evidence that Dr. Lawton considered other possible causes of claimant's wrist conditions is an October 1990 report that concerned claimant's right arm condition. (Ex. 6-1). There is no evidence Dr. Lawton considered other causes of claimant's left arm condition.[5]

In light of the failure of Drs. Nathan and Lawton to take into consideration any other potential causes of claimant's left wrist/forearm condition, we conclude that their opinions that claimant's condition was likely related to her work exposure are entitled to minimal weight. Accordingly, we conclude that claimant has failed to establish that her work activities were the major contributing cause of her left wrist/forearm condition.

In reaching this conclusion, we note that Dr. Nathan distinguished between a worsening of claimant's symptoms (which he concedes had occurred) and the onset or worsening of an underlying pathological condition (which he stated would be difficult to ascertain). (Exs. 11-6, 18). In light of Dr. Nathan's report, we conclude that the preponderance of the medical evidence does not establish that

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[4] Drs. Rogosin and Rohwer, who initially saw claimant for her right arm complaints, concurred with Dr. Nathan's opinion, although Dr. Rohwer indicated that he would also concur with Dr. Lawton's opinion. (Exs. 13-2, 14-2).

[5] Even if Dr. Lawton's October 1990 report concerned claimant's left arm, we would discount it because it only expresses claimant's, and not Dr. Lawton's, view regarding other potential causes for claimant's condition.

claimant's symptoms are her disease. See Teledyne Wah Change v. Vorderstrasse, 104 Or App 498 (1990). Accordingly, we conclude that claimant can meet her burden of proof only by establishing that the onset or worsening of a pathological condition in her left wrist or forearm was caused, in major part, by her work exposure. See id. Because the medical evidence fails to establish that claimant's work exposure was the major cause of the onset or worsening of an underlying pathological condition involving her left forearm or wrist, for this additional reason, we conclude that claimant has not met her burden of proof.

Because we conclude that claimant's left wrist/forearm condition is not compensable, we need not, and do not, address the remaining issues on review.

ORDER

The Referee's order dated August 3, 1993 is affirmed.

May 6, 1994 Cite as 46 Van Natta 885 (1994)

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case Nos. 92-16492 & 93-01866
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of those portions of Referee Galton's order that found that: (1) claimant's right shoulder and neck condition claim was prematurely closed; and (2) claimant's left foot injury claim was prematurely closed. On review, the issues are premature closure and, if the claims were not prematurely closed, extent of unscheduled permanent disability, temporary disability, and penalties. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Shoulder and Neck Condition

In July 1989, claimant compensably injured his right shoulder and neck while working as a custodian for the employer. Eventually, he was awarded 29 percent unscheduled permanent disability. As a result of a December 1991 fall at work, the employer accepted an aggravation of the right shoulder and neck condition. A Notice of Closure issued September 29, 1992, finding claimant medically stationary on September 10, 1992 and awarding an additional 7 percent unscheduled permanent disability. An Order on Reconsideration affirmed the Notice of Closure.

Premature Closure

The Referee concluded that claimant was not medically stationary on the date that the Notice of Closure issued, and set aside the Order on Reconsideration on the basis that the claim was prematurely closed. The employer challenges this conclusion, asserting that claimant failed to prove that he was not medically stationary at closure.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to show that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence thereafter, except that which pertains to changes in claimant's condition subsequent to closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987).

Dr. Gripekoven, orthopedist, treated claimant's shoulder and neck until he referred claimant to Dr. Wong, physiatrist, in March 1992. On August 25, 1992, Dr. Wong noted that claimant was "approaching a stationary point" and referred claimant for a physical capacities examination (PCE). (Ex. 147). The PCE report found that, in view of claimant's demonstrated "good range of motion and strength," claimant "should be able to be more functional than his current demonstrated level." (Ex. 150-4). The report further noted that claimant did not appear to "have the tolerances to perform custodial work[.]" (Id). A "fast track" work hardening program was recommended. (Id. at 5).

On September 10, 1992, Dr. Wong performed a closing medical examination, wherein he expressly found claimant medically stationary. (Ex. 151-4). The report also noted that the staff who performed the PCE thought that claimant "may make significant gains through a fast track program in working with his employer and vocational counselor in hopes of increasing his tolerance to allow him to return to a janitorial position" but, nevertheless, he "may not be able to return to the janitorial work force for the school district." (Id. at 1). Finally, Dr. Wong reported that claimant was "clear to return to work in a sedentary range" and to "consider modified fast track program to increase his physical capacities and return to work for the school district." (Id).

On September 29, 1992, Dr. Gripekoven concurred with Dr. Wong's closing examination report. (Ex. 155).

In light of Dr. Wong's references to the PCE report's recommendations for a work hardening program, the Referee found that claimant's condition was expected to improve with such treatment. We disagree.

Dr. Wong merely indicated that a work hardening program could be considered in order to increase claimant's physical capacities. Furthermore, Dr. Wong stated that, even with the program, it was possible that claimant would not be able to perform custodial work. We find that Dr. Wong's report is most reasonably construed as indicating only that a work hardening program possibly could increase claimant's physical capacities.

In view of Dr. Wong's express statement that claimant was medically stationary and our interpretation of his report, we find that his references to a work hardening program does not show that claimant was expected to materially improve with further treatment or the passage of time. See Maarefi v. SAIF, 69 Or App 527 (1984) (fluctuating symptoms and/or a need for continuing medical treatment does not necessarily mean a claimant's condition is not medically stationary); Alton H. Shotwell, 43 Van Natta 2421 (1993) ("post-closure" participation in a pain center program does not necessarily establish that claim was prematurely closed); Bobby G. Todd, 42 Van Natta 1648 (1990) (further testing and recommendations of physical therapy do not necessarily represent that further improvement could have been reasonably expected at claim closure). Therefore, we conclude that claimant did not carry his burden of proving that he was not medically stationary on the date of closure. Thus, his claim was not prematurely closed.

Finally, we note that the employer objects to consideration of that portion of a report by a rehabilitation consultant indicating that Dr. Wong had found claimant medically stationary, but wished to have claimant initially work for four hours per day and gradually increase to eight hours per day over a three week period. (See Ex. 152-2). Inasmuch as we have not relied on the report in reaching our conclusion that the claim was not prematurely closed, we need not address the employer's assertion regarding its admissibility. We proceed to consider extent of permanent disability.

Extent of Permanent Disability

The Order on Reconsideration affirmed the Notice of Closure's award of an additional 7 percent unscheduled permanent disability, which brought claimant's total award to 36 percent unscheduled permanent disability. The Order on Reconsideration found that claimant's SVP was 6, apparently based on the determination that his work as a self-employed bartender was most similar to that of Liquor Establishment Manager, DOT 187.167-126. (See Exs. 154, 166-1). Claimant asserts that, if we find that his claim was not prematurely closed, he is entitled to a total award of 48 percent unscheduled permanent disability. Specifically, claimant argues that the skills value should be 3, and further contends that he is entitled to an additional value under OAR 436-35-300(5).

The value for skills is based on the job having the highest SVP the worker has peformed during the ten years preceding the time of determination. OAR 436-35-300(4) (WCD Admin. Order 6-1992). First, we agree with claimant that Liquor Establishment Manager is not the appropriate category since there was no evidence that claimant hired, managed, and discharged other workers when working as a bartender. (Ex. 162-2). We also agree that claimant's work as a self-employed bartender is most similar to Bartender, DOT 312.474-010. Therefore, based on this job or claimant's work as a dispatcher, both of which he performed during the pertinent time period, the highest SVP achieved by claimant is 4. DOT 312.474-010, 379.362-010. (Ex. 162-3). Therefore, the appropriate value for skills is 3. OAR 438-15-300(4)(e).

Moreover, claimant is entitled to an additional value of 1 because he neither holds the appropriate license or certificate of completion nor achieved an SVP of 5 or higher during the ten years preceding the time of determination. OAR 436-35-300(5).

Neither party challenges the values of 18 percent for impairment, 1 for age, 0 for formal education, and 6 for adaptability, as determined on reconsideration. (Ex. 166-2). Adding the age and education factors results in a value of 5. See OAR 436-15-280(4). Multiplying that value with the factor for adaptability results in a value of 30. See OAR 436-35-280(6). Adding to that factor the impairment value results in a total award of 48 percent unscheduled permanent disability under the standards.

Because claimant previously was awarded 29 percent unscheduled permanent disability for his right shoulder and neck, we consider such award in arriving at the appropriate permanent disability for the current injury. See ORS 656.214(5); OAR 436-35-007(3)(b); Patrick D. Whitney, 45 Van Natta 1670, 1671 (1993). This determination requires a comparison of the current extent of disability under the standards with the prior permanent disability award to decide if the current award reflects any preexisting disability for which the claimant received benefits. OAR 436-35-007(3)(b); Patrick D. Whitney, supra. If the preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id.

When claimant was awarded 29 percent permanent disability in July 1991, he had been released to return to his regular job as a custodian, which is considered medium work. DOT 382.664-010; (Exs. 87-6, 95). However, claimant was limited from lifting over 60 pounds or performing overhead or above-shoulder work. (Id).

When claimant was declared medically stationary in September 1992, he was released to only sedentary work. (Exs. 151, 155). Moreover, he could not lift more than 20 pounds. (Ex. 153-2). However, the range of motion of his neck and right shoulder differed little from measurements taken for his prior closing examination and, in some cases, had improved. (Exs. 87, 151). In light of this evidence, we find that claimant's current disability award reflects his preexisting disability. However, we also find that claimant's earning capacity decreased since the July 1991 award, thereby entitling him to a portion of his current award under the standards. Specifically, we conclude that claimant is entitled to 19 percent unscheduled permanent disability, in addition to his prior award of 29 percent unscheduled permanent disability. Consequently, in addition to the Notice of Closure award of 7 percent unscheduled permanent disability (as affirmed by the Order on Reconsideration), claimant is awarded 12 percent.

Ankle Condition

Based on the December 1991 fall, the employer also accepted a left ankle sprain. On November 19, 1992, a Determination Order issued finding claimant medically stationary on October 26, 1992 and awarding 5 percent scheduled permanent disability. Claimant requested reconsideration, but did not contend that the claim had been prematurely closed. A panel of medical arbiters performed an examination, finding that claimant was not medically stationary with regard to his left foot. The Order on Reconsideration rescinded the Determination Order, finding this claim to be prematurely closed. The employer requested a hearing.

Premature Closure

The Referee first rejected the employer's assertion that the Department lacked jurisdiction to set aside the Determination Order because claimant had not disputed his medically stationary status when he requested reconsideration. Furthermore, the Referee found that claimant had proved that he was not

medically stationary at the time of the issuance of the Determination Order. Consequently, the Referee affirmed the Order on Reconsideration and awarded claimant a $2,000 carrier-paid attorney fee under ORS 656.382(2) for his counsel's efforts regarding the employer's hearing request.

On review, the employer again asserts that, because claimant did not request reconsideration regarding the issues of medically stationary date and premature claim closure, he is precluded from disputing such issues at hearing. The employer relies on our order 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. Based on the subsequent decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), the Board concluded that the holding in Mackey should no longer be given effect. See Darlene K. Bentley, 45 Van Natta 1719 (1993). Instead, the Board held that the parties at hearing may challenge any of the factors used by the Department in determining the claimant's permanent disability award. Id. at 1721.

Even more recently, we have addressed whether the issue of premature closure may be challenged at hearing if the question was not raised during reconsideration. Based on the rationale expressed in Bentley, as well as the promotion of administrative economy, we held that a claimant could properly raise the issue of premature closure at hearing even though it was not disputed at reconsideration. Ruth E. Griffin, 46 Van Natta 418 (1994). Thus, based on Griffin, we find that claimant in this case properly could challenge the Determination Order as having been prematurely issued.

Although we agree that the Referee properly addressed claimant's medically stationary status at the time of closure, we disagree that claimant proved that the claim was prematurely closed.

On October 26, 1992, Dr. Gripekoven found that claimant's left foot "should be considered medically stationary." (Ex. 144-2). Although noting that claimant continued to have pain in his foot and recommending "ongoing symptomatic care," Dr. Gripekoven also indicated that claimant required "no specific treatment." (Id).

Dr. Wong subsequently indicated that claimant's ankle condition was medically stationary as of September 10, 1992. (Exs. 179, 180).

In January 1993, claimant sought treatment from his family physician, Dr. Reynolds. According to Dr. Reynolds, claimant had "sustained an injury at home on 1/1/93 when he stepped off a porch causing aggravation to his left ankle and foot." (Ex. 173-1). Dr. Reynolds further indicated that claimant had "aggravated his foot and ankle problem," although there was no "underlying worsening" of his condition. (Id).

Claimant then underwent an examination by a panel of medical arbiters. The panel noted that in "December [claimant's] foot gave way, [and] there was increased pain[.]" (Ex. 174-2). The panel also found that claimant was not medically stationary. (Id. at 3).

In February 1993, claimant was examined by Dr. Puziss, orthopedic surgeon, at the employer's request. Dr. Puziss indicated that claimant's condition "should likely improve with a standard pair of custom orthodics" and, thus, was not medically stationary. (Ex. 178-4).

In March 1993, claimant underwent another examination at the employer's request by Dr. Farris, orthopedic surgeon, who found that claimant was medically stationary with regard to the December 1991 industrial injury. (Ex. 181-9).

As noted above, in determining whether claimant has proved that he was not medically stationary at closure, we examine medical evidence available at the time of closure, as well as evidence thereafter, except that which pertains to changes in claimant's condition subsequent to closure. Scheuning v. J. R. Simplot & Company, supra. According to Dr. Reynolds, the medical arbiter panel, and Dr. Farris, claimant experienced an increase in symptoms in January 1993. Based on this evidence,

we find that claimant's condition changed subsequent to closure. Medical reports by Dr. Reynolds, the medical arbiter panel, Dr. Puziss and Dr. Farris were based on examinations after the increase in symptoms and, therefore, pertained to claimant's changed condition subsequent to closure rather than his condition at closure. Thus, we do not consider such evidence in ascertaining claimant's medically stationary status at closure.

According to Dr. Gripekoven, claimant was medically stationary on October 26, 1992. Dr. Wong concurred with this assessment; although Dr. Wong rendered this opinion after claim closure, we consider such evidence since it pertained to claimant's condition at closure rather than his subsequent changed condition. There is no contrary evidence. Consequently, we conclude that claimant failed to prove that he was not medically stationary when the claim closed on November 19, 1992 and, thus, the claim was not prematurely closed.

Accordingly, we reverse those portions of the Referee's order that affirmed the Order on Reconsideration and awarded claimant a $2,000 carrier-paid attorney fee concerning the employer's then-unsuccessful appeal of the reconsideration order. We reinstate the Determination Order and proceed to rate the extent of claimant's scheduled permanent disability.

Extent of Permanent Disability

The only evidence on the record regarding impairment of claimant's right foot is the medical arbiter panel's report. Therefore, our findings regarding permanent disability are based on this report.

We first note that, contrary to claimant's assertion, there is no evidence of injury or disease to claimant's right foot and ankle. Therefore, the range of motion of claimant's left foot and ankle shall be compared to the contralateral joint in determining impairment. See OAR 436-35-007(16) (WCD Admin. Order 6-1992).

Claimant's ankle dorsiflexion was measured as 18 degrees on the right and 12 degrees on the left. (Ex. 174-3). Valued proportionately, claimant has 13.3 degrees of retained motion, resulting in 3 percent impairment. See OAR 436-35-190(6). Claimant's plantar flexion is 22 degrees on the right and 18 degrees on the left. (Ex. 174-3). Valued proportionately, claimant has 33 degrees retained motion, resulting in 3 percent impairment. See OAR 436-35-190(8). Claimant's subtalar inversion is 15 degrees on the right and 10 degrees on the left. (Ex. 174-3). Valued proportionately, claimant has 20 degrees retained motion, resulting in 2 percent impairment. See OAR 436-35-190(2). Claimant's subtalar eversion is 15 degrees on the right and 10 degrees on the left. (Ex. 174-3). Valued proportionately, claimant has 13.3 percent retained motion, resulting in 1 percent impairment. See OAR 436-35-190(4). Adding those values results in 9 percent impairment. See OAR 436-35-190(10).

We further agree with claimant that, because he experienced a calcaneal fracture and the medical evidence shows that he is unable to walk or stand for more than two hours during an 8-hour day, he is entitled to 15 percent. (Ex. 174-3, 174-4). See OAR 436-35-200(4). Combining this value with 9 percent impairment results in 23 percent permanent impairment.

We also agree that claimant is unable to repetitively use his left foot and, therefore, he is entitled to 5 percent impairment. (Ex. 174-4). See OAR 436-35-010(6). Combining this value with 23 percent impairment results in 27 percent scheduled permanent disability.

Temporary Disability

The Notice of Closure for claimant's shoulder claim awarded temporary total disability from December 13, 1991 through May 31, 1992 and temporary partial disability from June 1, 1992 through September 10, 1992. The Determination Order for claimant's left ankle claim awarded temporary partial disability from February 4, 1992 through October 2, 1992 less time loss paid for the shoulder claim.

After finding that claimant was not medically stationary, the Referee concluded that claimant was entitled to temporary disability for the ankle claim from September 22, 1992 to February 5, 1993, the date when the employer apparently reinstated such benefits. The Referee also assessed a penalty for the employer's failure to pay these benefits. The employer asserts that claimant is entitled only to the temporary disability awarded by the Notice of Closure and Determination Order.

A claimant's substantive entitlement to temporary disability is proven 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).

In June 1992, Dr. Wong released claimant to modified work. (Exs. 134, 138). On September 10, 1992, Dr. Wong indicated that claimant could perform "sedentary" work. (Ex. 151-3). On October 26, 1992, Dr. Gripekoven declared claimant medically stationary with regard to his left ankle.

Although apparently claimant stopped working some time after June 1992, based on the medical evidence, we find that claimant was partially disabled before being declared medically stationary October 26, 1992 for his left ankle condition. Inasmuch as claimant was not awarded temporary disability from October 2, 1992 to October 26, 1992, we conclude that he is entitled to temporary partial disability for such time period.

Finally, the employer objects to the Referee's imposition of a penalty for the employer's failure to pay temporary disability. The employer's only rationale for its failure to pay such benefits is that there was no authorization for time loss during the relevant period. (Tr. 20). Authorization for time loss is not necessary for proving substantive entitlement to temporary disability since such a determination is based on the entire record regarding a claimant's disability while the claim is in open status. SAIF v. Taylor, 126 Or App 658 (1994).

Based on Taylor, we find that the employer's basis for failing to pay temporary disability from October 3, 1992 to October 26, 1992 is not reasonable. Furthermore, as we found above, claimant was substantively entitled to temporary disability from October 3, 1992 through October 26, 1992. We find no evidence contradicting this conclusion. Consequently, we conclude that the employer's refusal to pay such benefits was unreasonable and that a penalty of 25 percent is warranted. See ORS 656.262(10). Claimant's attorney is entitled to one-half of this amount in lieu of an assessed fee. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

ORDER

The Referee's order dated June 2, 1993 is reversed in part, modified in part, and affirmed in part. Those portions of the order finding that claimant's shoulder and ankle claims were prematurely closed are reversed. Concerning the shoulder and neck claim, the Notice of Closure and Order on Reconsideration are reinstated. In addition to the Order on Reconsideration's award of 7 percent (22.4 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, bringing his entire award to date to 48 percent (153.6 degrees) unscheduled permanent disability. With regard to the ankle claim, the Determination Order is reinstated. In addition to the Determination Order's award of 5 percent (6.75 degrees), claimant is awarded 22 percent (29.7 degrees), bringing his total award to date to 27 percent (36.45 degrees) scheduled permanent disability.

The Determination Order regarding claimant's ankle claim is further modified to award claimant temporary partial disability for the period October 2, 1992 through October 26, 1992. Finally, claimant is awarded a penalty of 25 percent of the temporary disability benefits created by this order, one-half payable to claimant's attorney. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. This attorney fee is in lieu of the "out-of-compensation" fee awarded by the Referee's order. The Referee's $2,000 carrier-paid attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EARL PRETTYMAN, Claimant
Own Motion No. 94-0175M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left knee strain injury. Claimant's aggravation rights expired on May 11, 1986. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force. SAIF agrees that claimant's current condition requires surgery, and that he has sustained a worsening of the compensable injury.

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

In a January 31, 1994 chart note, Dr. Manley, claimant's treating physician, stated, "I think at this point we need to probably proceed with another arthroscopy and if this looks bad enough, I think [claimant] is going to need a total knee replacement on this side." In a February 22, 1994 chart note, Dr. Manley stated he had spoken to Ms. Meyer at SAIF, and she considered that claimant's arthroscopy would be considered diagnostic work-up. In its March 1, 1994 pre-certification review, CareMark Comp also identified the procedure as a left knee diagnostic arthroscopy.

On this record, we conclude that the arthroscopy is for diagnostic, rather than curative, purposes.[1] However, for purposes of reopening under its own motion authority, the Board has defined surgery as an invasive procedure which is undertaken for curative purpose. See Phillip E. Hager, 43 Van Natta 2291 (1991); Fred E. Smith, 42 Van Natta 1538 (1990). Thus, under a strict application of our definition of "surgery," claimant's diagnostic arthroscopy would not qualify to reopen claimant's own motion claim.

However, the reason for the distinction between "diagnostic" and "curative" surgery is to satisfy the statutory requirement of "a worsening of a compensable injury," which is one of the prerequisites of our authority to reopen a claim for own motion relief. ORS 656.278(1)(a). Under normal circumstances, the need for curative surgery for the compensable condition indicates a worsening of that condition. On the other hand, the need for diagnostic tests requiring surgery or hospitalization does not necessarily indicate a worsening of the compensable condition.

For example, diagnostic medical services are considered 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. Brooks v. D & R Timber, 55 Or App 688 (1982). However, the need for such diagnostic medical services, even if they involved surgery, would not necessarily indicate a worsening of the compensable condition.

Here, however, the record establishes that the need for the diagnostic arthroscopy was caused by a worsening of claimant's compensable condition. In his January 31, 1994 chart note, Dr. Manley stated:

> "[Claimant's] knee is becoming much worse. He has a walking tolerance now of about two to three blocks when he is doing well. He has night pain that awakens him frequently. He has difficulty going up and down stairs. He cannot squat or kneel. His wife has to put on his shoes and socks because of the fact he cannot bend his knee far enough to get them on."

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[1] OAR 436-10-005(29) defines what is and is not palliative care. In defining what is not palliative care, the rule includes "medical services rendered to diagnose, heal or permanently alleviate or eliminate an undesirable medical condition." Thus, nonpalliative care includes both diagnostic and curative treatment. See Gladys M. Theodore, 46 Van Natta 318 (1994).

On the basis of these findings, Dr. Manley concluded that claimant needed an arthroscopy to determine whether he needed a total knee replacement. On this record, we find that claimant's compensable condition worsened requiring surgery as of January 31, 1994. ORS 656.278(1)(a).

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). Here, claimant must establish that he was in the work force as of January 31, 1994, the time of his disability. 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, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current worsening or the time of surgery. Claimant has not responded to SAIF's contention. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

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.

May 6, 1994 Cite as 46 Van Natta 892 (1994)

In the Matter of the Compensation of
PATSY A. PUCKETT, Claimant
WCB Case No. 93-02886
ORDER ON REVIEW
Max Rae, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Referee Howell's order that: (1) declined to remand this matter to the Appellate Unit for another examination by a panel of medical arbiters; (2) denied claimant's request to continue the hearing in order to depose the medical arbiter; and (3) increased claimant's award of unscheduled permanent disability for a low back and hip injury from 2 percent (6.4 degrees) as awarded by Order on Reconsideration, to 20 percent (64 degrees). On review, the issues are remand, continuance, and extent of unscheduled permanent disability.

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

Claimant contends that the Referee erred in denying her request to continue the hearing in order to depose or cross-examine the medical arbiter. We disagree.

Inasmuch as ORS 656.268(6)(a) refers to "any medical arbiter report," the admissibility of a deposition of a medical arbiter is questionable. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). We need not address this question, however, as the admissibility of such a deposition is not squarely before us.

A Referee may continue a hearing for any reason that would justify postponement under OAR 438-06-081. See OAR 438-06-091. As the language of OAR 438-06-091 is permissive, the authority to continue a hearing rests within the Referee's discretion. See Sue Belucci, 41 Van Natta 1890 (1989). Finally, 438-06-091(2) requires a showing of due diligence if it is necessary to continue a hearing for the opportunity to cross-examine on documentary medical evidence.

Here, claimant did not present any circumstances that might justify postponing the hearing. Moreover, Dr. Snodgrass, the medical arbiter, issued his report on March 1, 1993. (Ex. 10). The hearing was not held until May 25, 1993. Thus, claimant had approximately three months prior to the hearing to depose Dr. Snodgrass. Thus, claimant has not shown that further information from Dr. Snodgrass could not have been obtained with due diligence prior to the hearing. OAR 438-06-091(2). Under these circumstances, the Referee did not abuse his discretion in declining to continue the hearing for the deposition or cross-examination of the medical arbiter. See Nina J. Butler, 46 Van Natta 523 (1994).

ORDER

The Referee's order dated August 16, 1993 is affirmed.

In the Matter of the Compensation of
HERMAN SIMPSON, Claimant
WCB Case No. 93-06253
ORDER ON REVIEW (REMANDING)
Craine & Love, Claimant Attorneys
Michael Whitty (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Brazeau's order which affirmed a Director's order under ORS 656.327(2) finding that a proposed emergency back-up power steering system for claimant's van was not an appropriate medical service. 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 emergency back-up power steering system for claimant's van was not an appropriate medical service. 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.

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). Furthermore, 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 Patricia D. Simmons, 45 Van Natta 2305 (1993); Peter Britz, 45 Van Natta 2187 (1993).

Here, the parties and the Referee believed that the scope of the Referee's review was limited to the record developed by the Director. No testimony was presented and the Referee excluded two proposed exhibits as supplemental to the Director's record. Under such circumstances, we conclude that

the record is incompletely developed and that there is a compelling reason to remand. ORS 656.295(5); Patricia D. Simmons, supra.[1]

Accordingly, we remand to Referee Brazeau 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 further evidence concerning whether the proposed emergency back-up power steering system for claimant's van is appropriate. The Referee shall then issue a final appealable order.

ORDER

The Referee's order dated September 13, 1993 is vacated. This matter is remanded to Referee Brazeau for further proceedings consistent with this order.

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[1] Here, the SAIF Corporation contends that the Board should dismiss claimant's request for review because, under Jefferson, neither the Director nor the Referee had jurisdiction to adjudicate the appropriateness of the proposed medical services. We disagree.

In requesting a hearing, claimant raised as issues the Director's order and medical services. Thus, claimant did not limit his hearing request to solely the Director's order under ORS 656.327(2).

Even if claimant had limited his hearing request, we would not be inclined to grant SAIF's dismissal. It is apparent that the foundation of this dispute is the propriety of the proposed medical service. Since the Jefferson court has determined that sole authority to resolve such disputes rests with this forum, and because SAIF has demonstrated no inclination to accede to claimant's demands for payment, we conclude that it achieves substantial justice and is in the interests of administrative economy to return this case to the Hearings Division for further development.

In the Matter of the Compensation of
CHRIS T. SINGELSTAD, Claimant
WCB Case No. 93-07575
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Referee Lipton's order that set aside its denial of claimant's left foot injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of employment.

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

Because the employer controls its premises, injuries that occur on the employer's premises typically arise out of and in the course of a worker's employment, unless an exception applies. Cope v. West American Ins. Co., 309 Or 232, 238 (1990). If the worker was engaged in a purely personal mission when injured, for example, his injury might not be sufficiently work-connected to be compensable.

In this case, we find no evidence that the employer benefited from its free firewood policy. However, because the wood was available only to employees and claimant was injured collecting and cutting the wood during his very brief paid break from work, we are not persuaded that the otherwise personal nature of his activity was sufficient to sever its work connection.

Moreover, based on claimant's testimony, we are persuaded that the employer was aware that employees collected and cut the wood, at the time of claimant's injury. Accordingly, we find that the employer did contemplate employee gathering and cutting of firewood.[1]

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[1] After claimant's injury, the employer prohibited chain saw cutting of firewood, with certain exceptions. Thus, we do not find that the employer currently contemplates the cutting of firewood by employees generally.

In addition, we acknowledge the difference between "contemplating" and "acquiescing." Here, although the employer generally acquiesced to claimant's use of its chain saw on the job,[2] we do not find that the employer specifically acquiesced to such use on paid break-time.[3] On the other hand, we do not find that the employer prohibited chain saw use on breaks at the time of claimant's injury.[4] Under these circumstances, we are not persuaded that claimant's activity at the time of his injury constituted a departure from his employment sufficient to defeat his claim.

Finally, because claimant sometimes did use a chainsaw on the job, we also agree with the Referee that risk of chainsaw injury was a risk of claimant's employment. See Folkenberg v. SAIF, 69 Or App 159 (1984) ("Where a specific work activity, whether isolated or repetitive, is part of a claimant's job, the risk of injury from that activity is a risk of that job"); Hubble v. SAIF, 56 Or App 154, 157 (1982) ("Walking was part of claimant's job; hence the risk of injury from walking was a risk of that job").

In summary, we conclude that the risk of this injury was a risk of claimant's employment; claimant was not on a purely personal mission at the time of injury; and the employer acquiesced generally with claimant's use of a chain saw at the workplace and specifically contemplated the cutting of firewood when it was collected. Under these circumstances, and because the injury occurred on the employer's premises during paid break time, we conclude that claimant has established that his injury arose out of and in the course and scope of employment.

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

ORDER

The Referee's order dated October 8, 1993 is affirmed. For services on review, claimant's counsel is awarded a $1,000 attorney fee, payable by the SAIF Corporation.

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[2] There is no contention that claimant was acting outside the scope of his employment when he occasionally traded jobs, which resulted in his use of a chain saw approximately one time during each shift.

[3] Although there is evidence that claimant sought and obtained permission to collect firewood on this occasion, there is no evidence that claimant similarly obtained express permission to use the employer's chain saw during this break.

[4] See note 1, supra.

May 6, 1994 Cite as 46 Van Natta 895 (1994)

In the Matter of the Compensation of
SARA J. SMITH, Claimant
WCB Case Nos. 91-06023 & 90-03508
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Barber's order that: (1) dismissed as untimely her hearing request against Sedgwick James, processing agent for Emanuel Hospital, a self-insured employer; and (2) affirmed an August 18, 1989 Determination Order which awarded 57 percent (182.4 degrees) unscheduled permanent disability for cervical and low back conditions. On review, the issues are jurisdiction, the timeliness of claimant's hearing request against Emanuel/Sedgwick concerning the August 18, 1989 Determination Order, the extent of permanent disability including permanent total disability and claim processing. We reinstate claimant's hearing request against Emanuel/Sedgwick and reverse in part and modify in part.

FINDINGS OF FACT

Claimant compensably injured her low back on May 21, 1985 while working for the Emanuel Hospital, which was then insured by the SAIF Corporation. (Ex. 1). The claim was accepted for low back strain.

On June 4, 1986, claimant suffered a second injury to her neck and upper back also while working for Emanuel. However, at the time of the June 4, 1986 injury, Emanuel was self-insured.

On November 12, 1986, Emanuel's processing agent (Fred S. James & Company, now Sedgwick James) partially denied claimant's low back condition. (Ex. 32). SAIF denied an aggravation claim on November 19, 1986. (Ex. 33). On May 26, 1987, an ORS 656.307 order issued designating SAIF as the paying agent. (Ex. 55). Claimant requested a hearing challenging both denials. A hearing was held and on October 1, 1987, Referee Lipton issued an Opinion and Order which found Emanuel/Sedgwick responsible for the low back condition, and upheld Emanuel/SAIF's denial. (Ex. 68). The 1986 Emanuel/Sedgwick claim was closed by a January 28, 1987 Determination Order with an award of 10 percent (32 degrees) unscheduled permanent disability. (Ex. 39A). The 1985 Emanuel/SAIF claim was closed by an October 8, 1987 Determination Order with an award of temporary disability only.

The 1986 Emanuel/Sedgwick injury claim was reopened for cervical surgery in August 1988 and was re-closed by a Determination Order dated August 18, 1989. (Ex. 130). The August 1989 "Emanuel/Sedgwick" Determination Order awarded 57 percent (182.4 degrees) unscheduled permanent disability and rated the low back as well as the cervical spine. The Determination Order listed Emanuel's claims processing agent (then Fred S. James) and gave the June 4, 1986 Emanuel/Sedgwick injury date and the Sedgwick (then Fred S. James) claim number.

On November 2, 1989, we reversed Referee Lipton's order and found SAIF responsible for claimant's low back condition. Emanuel/Sedgwick remained responsible for claimant's cervical condition.

On February 13, 1990, claimant requested a hearing on the August 18, 1989 "Emanuel/Segwick" Determination Order, raising unscheduled permanent disability, premature claim closure, aggravation, penalties, and attorney fees as issues. (Ex. A). The request for hearing listed Emanuel Hospital as the employer and SAIF as the insurer. The request for hearing was mailed to Emanuel Hospital and SAIF, but the request was not mailed to Sedgwick, Emanuel's processing agent. The hearing request specifically stated that it was an appeal of the August 18, 1989 Determination Order. On November 29, 1990, claimant filed an amended request for hearing raising the issue of permanent total disability. (Ex. B). This amended request was sent to Emanuel and SAIF, but not to Sedgwick. On May 14, 1991, claimant filed a supplemental hearing request raising the same issues. A copy of the supplemental hearing request was mailed to Sedgwick.

At the hearing, Emanuel/Sedgwick moved for dismissal of claimant's hearing request against them on untimeliness grounds. The Referee granted the motion to dismiss claimant's hearing request against Emanuel/Sedgwick in his February 4, 1993 order. With SAIF as the remaining party, the Referee proceeded to rate claimant's permanent disability stemming from the low back condition which had subsequently been determined to be SAIF's responsibility.

At the time of hearing, claimant had been providing in-home care to a disabled man for about a year under a contract with the Senior Services Division. Claimant measures the man's medication, cooks him meals and snacks, shops for groceries, does laundry, and takes him to doctor's appointments. (Tr. 36-38). Claimant testified that she receives about $400 a month for this work.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request Against Sedgwick/Emanuel

The Referee granted Sedgwick's motion to dismiss claimant's hearing request on the August 18, 1989 Determination Order on the grounds that there was no timely request for hearing against Emanuel/Sedgwick. We disagree.

On February 13, 1990, claimant filed a hearing request appealing the August 18, 1989 Determination Order which reclosed the 1986 Emanuel/Sedgwick claim. The hearing request listed Emanuel Hospital as the employer and SAIF as the insurer. The request was mailed to Emanuel Hospital and SAIF, but was not mailed to Sedgwick, Emanuel's processing agent for the 1986 claim. On November 29, 1990, claimant filed an amended request for hearing raising the issue of permanent total disability. (Ex. B). This hearing request was also only sent to SAIF and Emanuel. On May 14, 1991, claimant filed a supplemental hearing request raising the same issues. A copy of the supplemental hearing request was mailed to Sedgwick.

There is no dispute that claimant's first hearing request (dated February 13, 1990) was within 180 days of the date of Determination Order and, thus, was timely. ORS 656.268(6). The issue is whether the February 13, 1990 request was legally sufficient to constitute a request for hearing against Emanuel/Sedgwick on the August 18, 1989 Determination Order.

ORS 656.283(3) provides:

> "A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired and mailed to the board."

ORS 656.005(20) provides that "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." OAR 438-05-070 provides:

> "Proceedings before the Hearings Division are begun by filing a request for hearing meeting the requirements of ORS 656.283. The request for hearing should be on a form prescribed by the board. In addition to the information required by ORS 656.283(3), the person requesting a hearing should include the person's full name, the name of the injured worker if different from that of the person requesting the hearing, the injured worker's social security account number, the date of the injury or exposure, the name of the employer and its insurer, if any, and the claim number. A copy of the request should be mailed to the insurer or self-insured employer."

Here, the request for hearing listed Emanuel as the employer and SAIF as the insurer and gave the date of injury and claim number of the 1985 SAIF claim. However, the request specifically stated that it was an appeal of the August 18, 1989 Determination Order. That Determination Order closed the Emanuel/Sedgwick claim and gave the claim number and date of injury of the Emanuel/Sedgwick claim. Under the specific facts presented here, we conclude that claimant's hearing request on the August 18, 1989 Determination Order, which Emanuel received, was sufficient to constitute a hearing request against Emanuel/Sedgwick on the August 18, 1989 Determination Order.

Although a claim administrator or processing agent is not technically encompassed within the statutory definition of a "party," it stands as the functional equivalent of an insurer when an employer is self-insured. See ORS 656.005(20); Martin Manning, 40 Van Natta 374, 375 (1988) (where a copy of a referee's order was not mailed to the self-insured employer's claim administrator, the order was not final because a copy of the order had not been mailed to the functional equivalent of the employer's insurer). Thus, when requesting a hearing from the "Emanuel/Sedgwick" Determination Order, claimant should have provided Sedgwick with a copy of the hearing request. Nevertheless, claimant's failure to do so does not deprive the Hearings Division of jurisdiction over the Determination Order.

In reaching this conclusion, we analogize this situation to cases where a party appealing a referee's order neglects to mail a copy of the request for Board review to an opposing party, but does timely mail a copy of the request to a person or entity in privity with the opposing party. In such cases, in the absence of a finding that the opposing party has been prejudiced by not directly receiving a copy of the appealing party's request, timely service of the request on a person or entity in privity with the opposing party is sufficient for the Board to retain jurisdiction over the appeal. See Argonaut Insurance v. King, 63 Or App 847, 851-52 (1983); Nollen v. SAIF, 23 Or App 420, 423 (1983); Allasandra W. O'Reilly, 40 Van Natta 1180, 1181 (1988); Denise M. Bowman, 40 Van Natta 363 (1988).

Here, although a copy of the request for hearing was not mailed to Sedgwick, Emanuel's processing agent on the 1986 claim, a copy was timely provided to Emanuel, the employer. Inasmuch as there has been no showing that Sedgwick was prejudiced by its failure to receive a copy of the request, we conclude that claimant's hearing request should not have been dismissed.

Although OAR 438-05-070 prescribes that the date of the injury or exposure and the claim number should be included with the request for hearing, the language of the rule is not mandatory. See Guerra v. SAIF, 111 Or App 579, 584 (1992). Although we find Guerra distinguishable, we conclude that it is instructive here.

In Guerra, the claimant requested a hearing against one carrier raising the failure to pay interim compensation. Later, the claimant requested another hearing against a second carrier challenging that carrier's denial of her claim. The second request for hearing was filed more than 60 days after the carrier's denial. Relying on OAR 438-05-070, the court held that the earlier hearing request against the first carrier was not a sufficient hearing request on the second carrier's denial. The court held that a claimant has an obligation to request a hearing in response to each denied claim. The court noted that those statutes governing requests for hearing on denials evince a legislative intent that a request for hearing be referable to a particular denial. The court stated that ORS 656.283(3), as implemented by OAR 438-05-070, provides the procedural framework to accomplish that objective.

The present case involves a request for hearing from a Determination Order, not a denial. Thus, Guerra is distinguishable in that it involved a request for hearing on a particular carrier's denial and the claimant's obligation to request a hearing on each denial. However, Guerra does imply that a hearing request must be specific enough to inform the other party of the subject matter of the request. We conclude that the hearing request in the present case correctly identified the Determination Order which was being appealed and was mailed to the self-insured employer whose claim was closed by the Determination Order. Under such circumstances, we conclude that the hearing request was sufficient to inform Emanuel that a hearing was being requested against it on the Determination Order closing the 1986 claim. Emanuel, as a self-insured employer, was responsible for notifying its processing agent of the hearing request. Accordingly, we conclude that claimant's hearing request against Emanuel/Sedgwick was timely and we reinstate that hearing request.

August 18, 1989 Determination Order

As a result of Referee Lipton's order finding Emanuel/Sedgwick responsible for both the low back and the cervical/upper back conditions, the August 18, 1989 Determination Order closing the Emanuel/Sedgwick claim rated both the low back and cervical/upper back conditions. After issuance of the August 18, 1989 Determination Order, the Board reversed Referee Lipton's order and found SAIF responsible for the low back claim. Emanuel/Sedgwick remained responsible for the cervical/upper back conditions.

Claimant contends that the August 18, 1989 Determination Order should be set aside since it rates both the low back claim which is now the responsibility of SAIF under the 1985 injury claim and the 1986 cervical/upper back claim which remains the responsibility of Emanuel/Sedgwick. Claimant also contends that a single closure of both the 1985 and 1986 injury claims is unfair to her because she is entitled to have the factors for age, education, and adaptability separately rated for each of the two claims. We agree.

All parties agree that the August 1989 Determination Order was proper when issued since, when the Determination Order issued, Emanuel/Sedgwick was responsible for processing both the cervical and low back conditions. We are not aware of any authority for setting aside the properly issued Determination Order. However, we agree that claimant is entitled to have each condition separately rated. Both SAIF and Sedgwick argue that claimant is not entitled to have the age, education and adaptability factors separately rated because this would result in a "windfall" to claimant. We disagree.

This case involves two separate conditions and claims (the 1986 "new injury" claim against Sedgwick and the aggravation claim arising from the 1985 SAIF injury). Since there are two separate claims, each involving separate unscheduled injuries (Sedgwick - cervical/upper back; SAIF - low back), each claim would normally be separately rated and closed. Thus, there would be no "windfall" to claimant in having the age, education and adaptability factors separately rated for each claim. The low back claim was processed by Emanuel/Sedgwick on behalf of SAIF, the insurer ultimately found responsible. Although the low back condition is no longer the responsibility of Emanuel/Sedgwick, there are procedures for reimbursement between carriers by which Emanuel/Sedgwick can recover benefits from SAIF which it paid out in the low back claim. See ORS 656.307(3); OAR 436-60-190; OAR 436-60-195.

In addition, since that claim had been properly processed by Emanuel/Sedgwick and was already in closed status by the time SAIF became responsible for the low back, SAIF did not have to seek a further closure order from the Department or issue a Notice of Closure. See Diana L. Brett, 46 Van Natta 23 (1994) (Regardless of which carrier was ultimately found responsible in pending responsibility litigation, the claim was properly processed to closure by the carrier who was responsible for the claim at the time of closure). See also Nina J. Butler, 46 Van Natta 523 (1994) (The carrier which was responsible for the claimant's current condition, was also responsible for processing the claim, including the determination of permanent disability resulting from the claim, and could not join other carriers in the extent litigation). Inasmuch as the Determination Order rated both the low back and upper back/cervical conditions, we rate each claim separately. Accordingly, we proceed to rate claimant's permanent disability under the August 18, 1989 Emanuel/Sedgwick Determination Order.

Permanent Total Disability

Claimant contends that she is permanently and totally disabled.

In order to establish permanent total disability, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although she need not engage in job seeking activities that, in all probability, would be futile. SAIF v. Simpson, 88 Or App 638, 641 (1987). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, she is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

Dr. Reynolds is the only physician who opined that claimant was medically permanently and totally disabled. We find Dr. Reynolds' opinion unpersuasive for several reasons. First, we find Dr. Reynolds' conclusory statements that claimant is permanently and totally disabled unpersuasive without some explanation or analysis. Second, there is evidence that Dr. Reynolds relied on claimant's own conclusions regarding the level of her disability, rather than reaching that conclusion based on his own professional judgment. (Ex. 131-1,4). Finally, the surveillance films shown at hearing suggest that claimant is not as disabled as Dr. Reynolds has suggested. For these reasons, we conclude that claimant is not permanently and totally disabled from a medical standpoint.

We also conclude that claimant has failed to establish that she is permanently and totally disabled under the "odd-lot" doctrine. As previously discussed, in light of the surveillance films shown at hearing, we are not convinced that claimant is as physically restricted as Dr. Reynolds has indicated. For instance, Dr. Reynolds indicated that claimant should never lift or carry any weight up to five pounds. (Ex. 144). However, claimant was observed lifting and carrying a large box of laundry detergent, a fan and other groceries from her car up some stairs into her house without any apparent physical difficulty. (Tr. 180-184). Claimant was also observed to bend, stoop and twist while getting items out of her car without any apparent limitations or restrictions.

Three vocational experts opined that claimant was employable. Ms. Whitcombe opined that claimant was employable, assuming that Dr. Reynolds' lifting and carrying restrictions were wrong. Specifically, Ms. Whitcombe opined that claimant was employable, assuming she could lift and carry objects such as a few sheets of paper, a menu, a glass of water, or an object weighing about five ounces. (Tr. 247). Ms. Whitcombe identified jobs which were available and which claimant could perform without training, such as general clerk, appointment or information clerk, part-time hostessing, and telemarketing. Ms. Whitcombe opined that the work claimant had been performing for over a year as a companion and light housekeeper substantiated her employability. (Tr. 213). Mr. Lageman also opined that claimant was employable in the jobs identified by Ms. Whitcombe. Mr. Culbertson initially opined that claimant could not regularly perform gainful and suitable employment. However, after observing claimant at hearing and viewing the surveillance film, Mr. Culbertson also agreed that claimant was probably employable in some of the jobs listed by Ms. Whitcombe. (Tr. 301-302).

On this record, considering both the cervical and the low back conditions, we are unable to conclude that claimant is permanently and totally disabled under the "odd lot" doctrine. Because we have concluded on the basis of the vocational testimony that claimant is not precluded from gainful employment, we need not address whether claimant's current job as a companion is gainful and suitable employment.

Unscheduled Permanent Disability

The August 18, 1989 Determination Order awarded 57 percent (182.4 degrees) unscheduled permanent disability for the low back and cervical conditions. The applicable standards are those in effect on the date of the August 18, 1989 Determination Order. (WCD Admin. Order 1-1989).

We have concluded above that claimant is entitled to separate ratings for the low back and cervical/upper back claims. Because these claims are separate and are the responsibility of different insurers, claimant is entitled to have the age, education, and adaptability factors considered for each claim. However, to avoid redundancy, we only address the applicable age, education, and adaptability figures once, although we apply those factors to each claim.

Age

Claimant is over 40 years old, therefore she receives a value of 1 for age. Former OAR 436-35-290(4).

Education

Claimant has a GED certificate. Therefore, she receives no value for formal education. Former OAR 436-35-300(3)(a). The parties do not dispute that the highest specific vocational pursuit (SVP) during the ten years preceding the date of determination was an SVP of 5. Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4). Claimant has not demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is 1. Former OAR 436-35-300(5).

Adaptability

Here, claimant has returned to modified work providing in home care to a disabled man under a contract with the Senior Services Division. (Tr. 36-38). The adaptability value for a claimant who has either returned to modified work or received a work offer is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work, as a hospital housekeeper, required the physical capacity to do medium work. Claimant's modified work required a sedentary physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

Claimant has had a cervical discectomy and fusion at C4-C5 and C5-C6. Accordingly, claimant is entitled to an award of 13 percent impairment. Former OAR 436-35-350(2) and (3).

Claimant also has reduced cervical ranges of motion. Although the report of examining physicians Peterson and Fuller is more recent, these physicians noted multiple inconsistencies and marked evidence of symptom magnification in their examination. In addition, the attending physician did not concur with their impairment findings. Under the circumstances, we use the range of motion findings made by Drs. Kloos and Mandiberg (which were concurred in by claimant's treating doctor).

According to Drs. Kloos and Mandiberg, claimant had 30 degrees flexion, 40 degrees extension, 65 degrees right and left rotation, and 20 degrees right flexion and 25 degrees left flexion. Claimant has 6 percent impairment based on lost range of motion in the cervical spine. Former OAR 436-35-360(1)-(5). Claimant has 19 percent cervical impairment.

Claimant also had lost range of motion in the lumbar spine. Drs. Kloos and Mandiberg questioned the validity of their finding for flexion in the lumbar spine. However, they reported that claimant had 15 degrees extension, 15 degrees right flexion, 25 degrees left flexion, and 30 degrees right and left rotation. Thus, claimant has 6 percent impairment based on lost ranges of motion in the low back. Former OAR 436-35-360(6)-(9). Claimant has unoperated disc bulges at L4-5 and L5-S1. Thus, claimant is entitled to an award of 4 percent for each disc bulge. Former OAR 436-35-350(2). Claimant also contends that she is entitled to an award for a chronic condition limiting repetitive use of her low back. However, we find no persuasive evidence that claimant has such a chronic condition.

Computation of Unscheduled Disability Cervical/Upper Back Claim

The sum of the age and education factors (4) multiplied by the adaptability factor (2.5) equals 10. That figure is added to the value for claimant's impairment of the cervical spine (19) to equal 29. Claimant has 29 percent unscheduled permanent disability as a result of her upper back/cervical condition.

Computation of Unscheduled Disability Low Back Claim

The sum of the age and education factors (4) multiplied by the adaptability factor equals 10. That figure is added to the value for claimant's low back impairment (14) to equal 24. Claimant has 24 percent unscheduled permanent disability as a result of her low back condition.

We must now determine whether the August 1989 Determination Order must be modified to award further unscheduled permanent disability. Together, the cervical/upper back claim and the low back claim only equal 53 percent (169.6 degrees) unscheduled permanent disability, which is less than the 57 percent (182.4 degrees) unscheduled permanent disability awarded by the August 1989 Determination Order. Accordingly, we need not modify the Determination Order to award additional unscheduled permanent disability. Moreover, since neither carrier seeks reduction of claimant's total award, the 57 percent award shall not be disturbed.

The difference between the unscheduled permanent disability awarded by the Determination Order and the unscheduled permanent disability determined in this order is 4 percent. Thus, the question is how to distribute this 4 percent surplus between the SAIF and Sedgwick claims.

In light of such circumstances, we have pro-rated the 4 percent difference between the two claims in proportion to their respective awards. In other words, since SAIF's 24 percent award is approximately 45 percent of the 53 percent award, SAIF is responsible for 1.8 percent of that 4 percent difference. Because Sedwick's 29 percent award is approximately 55 percent of the 53 percent award, Sedgwick is responsible for the remaining 2.2 percent.

In conclusion, of the 57 percent (182.4 degrees) unscheduled permanent disability awarded by the Determination Order, Emanuel/Sedgwick is responsible for 31.2 percent (99.84 degrees) and SAIF is responsible for 25.8 percent (82.56 degrees). As we previously noted, there are procedures by which Emanuel/Sedgwick can seek reimbursement from SAIF for claim costs related to the low back claim.

ORDER

The Referee's order dated February 4, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that dismissed claimant's hearing request against Emanuel/Sedgwick is reversed. Claimant's hearing request against Emanuel/Sedgwick is reinstated. The August 18, 1989 Determination Order is modified to close both the Emanuel/Sedgwick "new injury" claim and the SAIF aggravation claim. The Determination Order is further modified. Instead of awarding 57 percent (182.4 degrees) for the Emanuel/Sedgwick claim, the Determination Order is modified to award claimant 31.2 percent (99.84 degrees) unscheduled permanent disability for the Emanuel/Sedgwick cervical and upper back injury claim and to award claimant 25.8 percent (82.56 degrees) unscheduled permanent disability for the SAIF low back claim.

In the Matter of the Compensation of
LINDA K. TRUEBLOOD, Claimant
WCB Case No. 92-13340
ORDER ON REVIEW
Max Rae, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Holtan's order that: (1) upheld the SAIF Corporation's denial of claimant's disability or need for treatment for her compensable left shoulder injury; and (2) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In April 1988, claimant experienced a non-work-related left shoulder condition diagnosed as rotator cuff tendinitis or adhesive capsulitis. Her symptoms resolved by mid-1989.

In May 1991, claimant developed pain in her left shoulder after she performed data entry on the job for eight hours a day for two consecutive days. Dr. Neuberg, her attending physician, diagnosed a shoulder strain, treated her conservatively, and restricted rotation and reaching by the left upper extremity. (Ex. 2). Claimant's condition did not improve. X-rays and an MRI showed mild disc degeneration at C4-5. (Exs. 6 and 7). On May 31, 1991, Dr. Corrigan, orthopedic consultant, evaluated claimant's condition. He eliminated the degenerative condition as causative and diagnosed mild rotator cuff tendinitis. (Exs. 10 and 10A). Claimant filed a claim for her left shoulder condition which SAIF denied. Dr. Neuberg treated her on June 27, 1991 and ordered a worksite evaluation, which was done. (Exs. 11 and 11B).

On September 18, 1991, Drs. Peterson and Fuller examined claimant for SAIF. Claimant reported that her left shoulder had not improved, but she had not sought further medical treatment. (Ex. 13-2).

A hearing was held on December 6, 1991. In a March 26, 1992 order, a prior referee concluded that claimant's left shoulder injury claim was compensable and remanded the claim to SAIF for acceptance and processing according to law. In so concluding, the referee found that claimant's data entry work was a material contributing cause of her subsequent need for treatment. (Ex. 17). The referee also stated, "Whether SAIF pursues a partial denial of claimant's ongoing medical treatment at a later date is a matter not before me." (Ex. 17-5). SAIF requested Board review. In a November 25, 1992 Order on Review, the Board affirmed and adopted the prior referee's order. This Order on Review was not appealed and has become final.

Subsequent to treating for her shoulder, claimant treated for right arm problems, which SAIF accepted under a separate claim that is not subject to this proceeding. (Exs. 14D, 14E, 19A and 25C).

On March 17, 1992, claimant returned to Dr. Neuberg for worsening left shoulder complaints. Dr. Neuberg diagnosed chronic left shoulder tendinitis and injected claimant's left shoulder. (Ex. 16). The injection was not successful. On April 7, 1992, Dr. Neuberg referred claimant to Dr. Moore at the Salem Hospital Regional Rehabilitation Center for evaluation. (Exs. 15 and 18). Dr. Moore diagnosed mild rotator cuff tendinitis and possible somatization syndrome and declared claimant to be an appropriate candidate for the Chronic Work Injury Management Program (CHRIMP). (Exs. 20-3 and 23C-3). Dr. Neuberg approved the treatment plan. (Ex. 20A-2). SAIF refused to approve the program. (Exs. 24 and 25D). By June 23, 1992, claimant was no longer under consideration for the CHRIMP program based on her shoulder injury. (Ex. 25F).

On September 22, 1992, SAIF issued a denial, which stated in pertinent part:

> "Because of SAIF Corporation's duty to process your claim pending appeal, SAIF Corporation hereby issues a denial of treatment and disability for your May 1, 1991 injury to your left shoulder. While the referee found the injury to be a material

contributing cause of your need for treatment, the major cause of disability and need for treatment is your pre-existing left shoulder condition. Therefore, we must deny your claim." (Ex. 26).

On November 11, 1992, Dr. Neuberg released claimant to regular work in regard to her left rotator cuff tendinitis. (Ex. 29).

On December 22, 1992, Drs. Peterson, neurologist, and Fuller, orthopedic surgeon, performed an examination of claimant's left shoulder for SAIF. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

The Referee characterized SAIF's September 22, 1992 denial as a current condition denial rather than a denial of the compensability of the initial claim, which had been previously litigated to a final judgment. The Referee applied an "issue preclusion" analysis to find, among other determinative facts, that claimant has a preexisting condition identified as "bilateral anterior impingement syndrome" of the shoulders. The Referee then required claimant to prove that her industrial injury "remains the major contributing cause of the disability or need for treatment" of the resultant condition, i.e., the symptomatic left shoulder impingement syndrome, pursuant to ORS 656.005(7)(a)(B). Concluding that claimant had failed to satisfy this requirement, the Referee upheld SAIF's denial.

On review, claimant contends that issue preclusion did not bar the Referee from deciding whether claimant had a preexisting condition, because that fact was not essential to the prior judgment. We agree.

Preexisting Condition

We begin our analysis by revisiting Bahman M. Nazari, 43 Van Natta 2368 (1991), as of the time of the prior referee's decision.[1]

In Bahman M. Nazari, we had limited the application of ORS 656.005(7)(a)(B) to cases in which the claimant had first established that there was a compensable injury, i.e., that the work was a material contributing cause of the injury. Then, if it was determined that the compensable injury combined with a preexisting disease or condition to cause or prolong disability or the need for treatment, that disability or treatment would be compensable only if the compensable injury was the major contributing cause of the disability or need for treatment. Thus, even though an injury was shown to be compensable, we concluded that a worker may not be entitled to claimed compensation for particular medical services or disability if the compensable injury was not the major cause thereof.

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[1] Subsequent to the prior referee's order, the Court of Appeals issued Tektronix, Inc., v. Nazari, 117 Or App 409 (1992), in which it concluded that the two-step analysis set forth in Bahman M. Nazari was not intended by the legislature, as such a process would require an employer to accept a claim for which no benefits were due. Instead, the court held that when a work-related injury combines with a preexisting condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment. Id. at 412. Although SAIF's denial issued after Tektronix, Inc., v. Nazari, supra, the holding in the case does not affect our analysis of whether issue preclusion bars claimant from litigating the existence of a preexisting condition.

Subsequent to the Referee's order before us, the Court of Appeals reconsidered and modified its decision. Tektronix, Inc., v. Nazari, 120 Or App 590 (1993). It held the following: (1) 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; (2) 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; and (3) In order to obtain further compensation for disability or a need for treatment that is the result of a combination of the injury and a preexisting, noncompensable condition, the claimant must show that the injury is the major contributing cause of the disability or need for treatment.

The prior referee concluded that claimant had established that her accidental injury was a material contributing cause of her need for treatment. (See Ex. 17-4). However, unlike Bahman M. Nazari, in which we applied both steps of the analysis to the facts of the case, the prior referee stated, "Whether SAIF pursues a partial denial of claimant's ongoing medical treatment at a later date is a matter not before me." (Ex. 17-5). The prior referee did not directly address whether claimant was entitled to any compensation as a result of his order. Thus, we conclude that the holding was limited solely to the compensability of the injury under the first step of our Nazari analysis.

Therefore, although the prior referee found that claimant had a preexisting condition, inasmuch as he did not apply the second step of our Nazari analysis, we conclude that his finding of a "preexisting condition" was not essential to his conclusion that the injury was compensable. Consequently, the parties were not precluded from litigating at hearing the issue of whether or not claimant had a preexisting condition which combined with the industrial injury to cause disability or the need for treatment. See Cates v. Jordison, 126 Or App 588 (1994).

We next turn to claimant's contention that her bilateral impingement syndrome, if any, is a predisposition and not a preexisting condition. We first note that claimant has been diagnosed with two allegedly "preexisting" conditions, bilateral anterior impingement syndrome and degenerative disc disease at C4-5. We address them separately.

In their September 18, 1991 report, Drs. Peterson and Fuller, who examined claimant for SAIF, "suspected" that, if x-rays were taken, it would be revealed that claimant had a hooked acromion, resulting in a preexisting bilateral anterior acromial impingement syndrome. (Ex. 13-3). Such x-rays were never taken. Then, in their December 22, 1992 report, the same doctors diagnosed a mild bilateral anterior acromial impingement syndrome, but concluded that it did not contribute to claimant's pain complaints. (Exs. 31-3, 31-5 and 31-6). However, although SAIF's doctors for the left shoulder claim say that she has an impingement syndrome, SAIF's doctors for her right arm say that she does not. (Compare, e.g., Ex. 13-3 with Ex. 28-5). In addition, no other treating or examining doctor diagnosed this condition. Thus, whether claimant has an impingement syndrome is speculative, at best. Consequently, we do not find Drs. Peterson and Fuller's opinion persuasive and do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we do not find that claimant had a preexisting left shoulder condition.

X-rays and an MRI showed mild disc degeneration at C4-5. (Exs. 6 and 7). In 1991, Dr. Corrigan, orthopedic consultant, eliminated the degenerative condition as causative and diagnosed claimant's condition as rotator cuff tendinitis caused by claimant's work injury. When claimant sought treatment in 1992, Dr. Neuberg diagnosed claimant's condition as chronic rotator cuff tendinitis.

In contrast to their September 1991 report, in which they attributed claimant's left shoulder condition to the impingement syndrome, as discussed above, in their December 1992 report, Drs. Peterson and Fuller relied on the x-rays and MRI to conclude that claimant's left shoulder condition was caused by degenerative disc disease at C4-5 "which [has] been chronic for many years . . . [and which is] more than enough to account for her current pain syndrome." Although Drs. Peterson and Fuller had the same x-rays and MRI at the time of their earlier report, neither they nor any other doctor attributed claimant's left shoulder pain in either 1988 or 1991 to her degenerative condition. Furthermore, their report does not explain how or when their earlier hypothesized impingement syndrome ceased being the cause of claimant's need for treatment and the degenerative condition became the cause.

Consequently, although claimant has a diagnosed degenerative condition at C4-5, we are not persuaded that it has any causative relationship to her left shoulder complaints. See Somers v. SAIF, supra. Thus, inasmuch as claimant's degenerative condition has no causal relationship to her current left shoulder condition, we do not find that claimant's compensable injury combined with a preexisting condition. Therefore, we conclude that claimant need not establish that her compensable injury is the major contributing cause of her disability and need for treatment. See ORS 656.005(7)(a)(B); Gary Stevens, 44 Van Natta 1178 (1992).

Compensability

Claimant has previously established that the industrial injury to her left shoulder is compensable. We are persuaded by the opinions of Drs. Neuberg, Corrigan and Moore that claimant has left rotator cuff tendinitis. Drs. Neuberg and Corrigan opined that claimant's need for treatment for

her left shoulder condition was her work. Consequently, claimant has proven that her injury is a material cause of her need for treatment and disability, and thus her treatment and disability continues to be compensable. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

Penalty and Attorney Fees

In determining if a denial is unreasonable, the question is whether SAIF had a legitimate doubt as to its liability at the time of its denial. If SAIF based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). SAIF's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. Given the prior referee's finding that claimant's work was a material contributing cause of her subsequent need for treatment and refusal to address the compensability of claimant's future treatment, as well as our analytic scheme in Bahman M. Nazari, supra, we conclude that SAIF had a legitimate doubt about compensability of disability and treatment in this case.

Furthermore, SAIF continued to have a legitimate doubt about compensability of disability and treatment after the Court of Appeals issued Tektronix, Inc., v. Nazari, 117 Or App 409 (1992) (when a work-related injury combines with a preexisting condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment). Consequently, we conclude that its denial was not unreasonable. Thus, we decline to assess a penalty or related attorney fee.

Assessed Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of her disability and need for treatment 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 February 12, 1993, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the SAIF Corporation.

May 6, 1994 Cite as 46 Van Natta 905 (1994)

In the Matter of the Compensation of
ROSE M. WAKEFIELD, Claimant
WCB Case No. 93-08183
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of Referee Lipton's order assessing a penalty under ORS 656.268(4)(g). In her respondent's brief, claimant contests that portion of the Referee's order that declined to award an attorney fee under ORS 656.382(1) for allegedly unreasonable claim processing. On review, the issues are penalties and attorney fees.

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

A claimant is automatically entitled to a penalty under ORS 656.268(4)(g) when the statutory requirements are met. Kevin Northcut, 45 Van Natta 173 (1993). Those two conditions are satisfied in this case: (1) claimant is at least 20 percent permanently disabled; and (2) the Department ordered an increase by 25 percent of the amount of compensation to be paid to the claimant for permanent disability. ORS 656.268(4)(g). Since the statutory requirements are met, claimant is entitled to a penalty in the amount of 25 percent of all compensation due as a result of the June 29, 1993 Order on Reconsideration, without regard to whether the carrier's action was reasonable. Id.

The employer argues that application of ORS 656.268(4)(g) violates its constitutional protection from "ex post facto" laws. (App. Br. at 2). There is no constitutional prohibition to the legislature providing that Workers' Compensation laws be applied retroactively. Hall v. Northwest Outward Bound School, 280 Or 655, 661 (1977); Carl M. Keeton, 44 Van Natta 664, 665 (1992). Ex post facto laws are limited to criminal laws. Id. Accordingly, we do not find the application of ORS 656.268(4)(g) to claimant's case to be unconstitutional.

Claimant argues that the Referee erred when he refused to assess an attorney fee pursuant to ORS 656.382(1). As represented by claimant's closing arguments, the only issue raised before the Referee was whether to award a penalty pursuant to ORS 656.268(4)(g). Therefore, we decline to consider the issue now since it was not raised before the Referee. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

ORDER

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

May 6, 1994 Cite as 46 Van Natta 906 (1994)

In the Matter of the Compensation of
MICHAEL R. WICKSTROM, Claimant
WCB Case No. 91-11489
ORDER ON REMAND (REMANDING TO DIRECTOR"S APPELLATE UNIT)
Max Rae, Claimant Attorney
Garrett, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Wickstrom v. Norpac Foods, Inc., 125 Or App 520 (1993). The court has reversed our prior order, Michael R. Wickstrom, 45 Van Natta 524 (1993), 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. Citing Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

An April 26, 1991 Notice of Closure closed claimant's injury claim with an award of 100 percent scheduled permanent disability for injury to the right arm. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The August 30, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Notice of Closure in all respects. In addition, the Order on Reconsideration recognized that claimant was entitled to an examination by a medical arbiter and indicated that the Appellate Unit would schedule the claim for a medical arbiter review pursuant to ORS 656.268(7). (Ex. 43A).

A medical arbiter's examination did occur on September 3, 1991. The medical arbiter identified shoulder impairment due to injury to claimant's axillary nerve, as well as reduction in claimant's chest-wall expansion. (Ex. 45). Claimant requested a hearing regarding extent of scheduled and unscheduled permanent disability, as well as penalties and attorney fees under ORS 656.268(4)(f) and (g) for an allegedly unreasonable failure to award unscheduled permanent disability.

At hearing, both the self-insured employer and claimant asked the Referee to consider the entire record, including the medical arbiter's report. The Referee, however, 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. Michael R. Wickstrom, supra. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

In Pacheco-Gonzalez supra, 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.

Penalty and Attorney Fee issues

At the outset, we note that claimant has raised penalty and attorney fee issues which neither the Referee nor the Board addressed in its prior orders. With respect to claimant's request for a penalty under ORS 656.268(4)(g), the Board does have the authority to assess a penalty under that statute, which provides for assessment of a 25 percent penalty when a reconsideration order increases a permanent disability award by 25 percent and the claimant is at least 20 percent permanently disabled. See Steven L. Cline, 46 Van Natta 512 (1994) (partially disavowing Vena K. Mast, 46 Van Natta 34 (1994)). However, ORS 656.268(4)(g) is not presently applicable because the Order on Reconsideration did not increase claimant's permanent disability as required by that provision.

Claimant also requests a penalty under ORS 656.268(4)(f), which authorizes assessment of a 25 percent penalty should a finding be made at hearing that a Notice of Closure was not reasonable. Specifically, claimant contends that a penalty should be assessed for the employer's failure to award unscheduled permanent disability in its Notice of Closure. We disagree.

We have recently applied ORS 656.268(4)(f) in a claim where the employer had no reasonable basis for declaring a claimant medically stationary and closing the claim. See Cindy A. Schrader, 46 Van Natta 175 (1994). However, we have serious doubts as to whether ORS 656.268(4)(f) applies to an allegedly unreasonable failure to pay permanent disability, particularly in light of ORS 656.268(4)(g), as well as the general penalty assessment authority for unreasonable resistance to the payment of compensation in ORS 656.262(10). Nevertheless, even if ORS 656.268(4)(f) is applicable, we do not find the employer's failure to award unscheduled permanent disability to have been unreasonable.

Our review of the medical evidence prior to the employer's April 26, 1991 Notice of Closure leads us to conclude that it was reasonable for the employer not to include an unscheduled award prior to claim closure. Dr. Moore, claimant's attending physician, stated that claimant's shoulder motion was "significantly limited due to joint capsule tightness." However, Dr. Moore did not identify a separate pathological source for claimant's shoulder dysfunction apart from claimant's brachial plexus injury, for which only scheduled impairment is provided. See OAR 436-35-110(8). It was not until the "post-closure" medical arbiter's examination that unscheduled permanent impairment was clearly identified. Under these circumstances, we do not find that the employer unreasonably failed to make an unscheduled permanent disability award.

Moreover, for these same reasons, we do not find that claimant is entitled to an attorney fee under ORS 656.382(1) for an allegedly unreasonable resistance to the payment of compensation. We, therefore, reject claimant's contention that he is entitled to such an award.

Remand

On September 3, 1991, Dr. Gritzka performed a medical arbiter's examination in which he reported that claimant had a 50 percent loss of chest-wall expansion. (Ex. 45-5). Both parties agree that the "standards" do not provide a specific rule covering this kind of impairment. Claimant did not request promulgation of a temporary rule pursuant to ORS 656.726(3)(f)(C) during the reconsideration process. Claimant did allege, however, in correspondence to the Referee on December 6, 1991, that the Department erred in not adopting a temporary rule to address claimant's alleged chest-wall impairment. Claimant also requested a remand to the Director for adoption of a temporary rule while this matter was on Board review.

We have the authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. See Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). However, we have refused to exercise this authority where a request for remand to the Director is first made during reconsideration of a Board order. See Brian G. Vogel, 46 Van Natta 225 (1994). In addition, we have also declined to remand where a claimant neither requested the Director to adopt a temporary rule nor requested the Referee or the Board to remand the claim to the Director. See Kelly D. Mustoe, 46 Van Natta 285 (1994).

We find Vogel and Mustoe to be distinguishable. In contrast to those cases, claimant, here, raised the issue of a temporary rule to address his alleged chest-wall impairment before the Referee as well as the Board. Although claimant did not request the Director to adopt a temporary rule, it was not until after the August 30, 1991 Order on Reconsideration had issued that the medical arbiter's examination occurred. The medical arbiter's report for the first time measured claimant's reduction in chest-wall expansion, thereby indicating that claimant suffered a disability not addressed by the standards. Under these circumstances, we conclude that claimant's request at hearing for remand to the Director for adoption of a temporary rule was timely.

In conclusion, without expressly finding that the existing standards adequately addressed claimant's disability, the Director issued an Order on Reconsideration affirming a Notice of Closure, which did not award any permanent disability for claimant's reduction in chest-wall expansion.

We are compelled to remand to the Director upon a finding that, at the time of the issuance of an Order on Reconsideration, a disability was not addressed by the existing standards and the Director neglected to stay further proceedings and adopt a temporary rule. See ORS 656.726(3)(f)(C); Gary D. Gallino, on remand, 46 Van Natta 246 (1994).

Accordingly, we conclude that the Director was required to stay the reconsideration proceedings and promulgate a temporary rule regarding claimant's disability. Id. Likewise, since we are not authorized to adopt such a rule, we are required to remand to the Director for promulgation of that rule.

Therefore, the Referee's order dated December 23, 1991, as reconsidered on January 9, 1992, is vacated. Claimant's hearing request is reinstated, but his current request for penalties and attorney fees is denied. In accordance with the Gallino decision, we remand this case to the Director for further proceedings consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL K. BEVIER, Claimant
WCB Case No. 91-15953
SECOND ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

On February 9, 1994, we issued an Order on Reconsideration which held that claimant was not entitled to a carrier-paid attorney fee for finally prevailing on review regarding a dispute concerning claimant's prescription medication and medical treatment to monitor the medications. Daniel K. Bevier, 46 Van Natta 215 (1994). Claimant has petitioned for judicial review of our order. On April 15, 1994, we withdrew our order for further consideration. See ORS 183.482(6); ORAP 4.35. In doing so, we announced our intention to reexamine the issue of claimant's entitlement to an attorney fee award under ORS 656.386(1). Having completed that reexamination, we issue the following reconsideration order.

Claimant suffers from a psychological condition which has been determined to be a compensable part of his 1987 industrial neck injury. His claim is in closed status. Claimant's treating psychiatrist, Dr. Brown, has prescribed medications for the treatment of claimant's psychological condition. Specifically, the medications are designed to maintain and possibly improve claimant's condition. Without such medication, claimant's psychological condition would deteriorate.

The self-insured employer neither challenged the compensability of claimant's psychological condition nor the causal relationship between the medication / treatment and the compensable condition. Instead, the employer declined to grant Dr. Brown's request for palliative care under ORS 656.245(1)(b). (Ex. 2). More than 90 days after the employer's notice, claimant requested a hearing. At the hearing, the employer contended that certain medical treatment was palliative and, therefore, not compensable, while claimant contended the treatment was curative and compensable, or alternatively, that it was compensable palliative care. (See Tr. 1-3).

Reasoning that jurisdiction over the dispute rested with the Director, the Referee dismissed claimant's hearing request. On review, we held that we retained jurisdiction to determine whether claimant's medication and treatment was compensable palliative care under ORS 656.245(1)(b). Daniel K. Bevier, 46 Van Natta 41 (1994). Finding that the prescriptions and treatment were compensable, we determined that we were authorized to resolve the dispute. Consequently, we directed the employer to pay for the disputed medications and office visits.

Thereafter, claimant requested reconsideration, seeking a carrier-paid attorney fee under ORS 656.386(1) for his counsel's services at hearing and on Board review. On reconsideration, we concluded that claimant was not entitled to such an award. Citing SAIF v. Allen, 124 Or App 183 (1993), we reasoned that claimant was not entitled to a carrier-paid attorney under ORS 656.386(1) because the dispute did not pertain to the "compensability" of the claim.

While claimant's petition for judicial review of our order was pending, we withdrew, on our own motion, our reconsideration order. We took this action to reexamine our conclusion that claimant is not entitled to a carrier-paid attorney fee award. Having completed our further consideration of this issue, we hold that claimant is entitled to a carrier-paid attorney fee under ORS 656.386(1). We base this conclusion on the following reasoning.

In Gwen A. Jackson, 46 Van Natta 357 (1994), on recon 46 Van Natta 822 (1994), we examined the court's plurality opinion in SAIF v. Allen, supra. Reasoning that neither the "lead" nor concurring opinion were of any precedential value, we reexamined the relevant Supreme Court decisions for further guidance in analyzing the application of ORS 656.386(1). Based on our review of those decisions (Short v. SAIF, 305 Or 541 (1988), and Shoulders v. SAIF, 300 Or 606 (1986), among others), we determined that a claimant was entitled to an attorney fee award under ORS 656.386(1) for finally prevailing against an order or decision denying a medical services claim. We identified the critical inquiry as whether the carrier's conduct constitutes a decision denying the claimant's claim for compensation.

In Jackson, the carrier notified claimant and her physician that a proposed surgery was excessive, inappropriate and ineffectual treatment. Recommending that the physician withdraw the

surgery request, the carrier further advised that if the request was not withdrawn the physician should seek Director review under ORS 656.327. When the claimant requested a hearing, the carrier's position at hearing was that the proposed surgery was neither reasonable nor necessary. The carrier did not dispute that the surgery was causally related to the claimant's compensable condition. Notwithstanding the carrier's notice that it had not and would not issue a denial of the proposed treatment, we reasoned that the carrier's response to the physician's surgery request and its position at hearing constituted a "decision denying the claim for compensation." Inasmuch as we found the surgery to be appropriate, we held that the claimant was entitled to a carrier-paid attorney fee award under ORS 656.386(1) for her counsel's services at hearing and on review.

Here, as in Jackson, the employer has not contested the causal relationship between claimant's medical services claim and his compensable condition. Nevertheless, again as in Jackson, the employer has challenged claimant's entitlement to such services. In light of such circumstances, we conclude that the employer's refusal to grant claimant's treating physician's request for payment of medication and related treatments, as well as its objection to claimant's contention that his medical services claim was for compensable palliative care, constitutes a "decision denying the claim for compensation." Since claimant has finally prevailed on Board review over that denied medical services claim, we hold that he is entitled to an attorney fee award under ORS 656.386(1) for his counsel's services at the hearing and on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review regarding this claim is $3,600, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, 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 counsel might go uncompensated.

Accordingly, on reconsideration, as modified herein, we republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 11, 1994 Cite as 46 Van Natta 910 (1994)

In the Matter of the Compensation of
MICHAEL J. GALBRAITH, Claimant
WCB Case No. C4-00797
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Member Gunn, Westerband and Neidig.

On March 29, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On April 27, 1994, the Board received a "Notice of Claim for Attorney's Lien" and a copy of a billing statement from claimant's former counsel. Counsel states that she represented claimant for ten months and was in the process of negotiating a CDA with the SAIF Corporation when claimant changed attorneys. Counsel's billing statement indicates that she performed 55.5 hours of work for a total of $8,435. Portions of the statement expressly pertain to settlement negotiations. Counsel states that she is willing to compromise her bill for $4,000, and claims a lien in that amount from the proceeds of this CDA.

On April 29, 1994, the Board requested that the parties, including claimant's current counsel, respond to the lien notice within ten days. The Board further directed the parties' attention to a prior Board case, Ronald C. Kendall, 43 Van Natta 2388 (1991). In Kendall, we held that the manner in which the fee is to be distributed to the claimant's current and former counsel was a matter to be decided

between the two of them, and not by this forum. In Kendall, the claimant's current counsel acknowledged the representation by prior counsel, and agreed that the attorney fee generated by the agreement should be disbursed equally between counsels. In light of such an acknowledgement, we directed the carrier to issue a check for attorney fees payable to both counsels.

We have received the parties' responses in this case. Claimant's current counsel has acknowledged that former counsel made asettlement offer on behalf of claimant which was ultimately rejected by SAIF. Although claimant's current counsel does not agree that former counsel is entitled to the entire requested amount of $4,000, he is "willing to pay her a reasonable attorney fee of $1,200 for her services." Based on this concession by claimant's current counsel, as well as claimant's former counsel's billing statement referencing services pertaining to settlement negotiations, we conclude that former counsel has rendered services pertaining to the CDA, on behalf of claimant. Furthermore, we note that claimant's former counsel has provided a signed and notarized notice, in which former counsel has attested to a sum of $4,000, as a true and bona fide existing debt.

Under the circumstances, we conclude that this matter is similar to Kendall, supra, insofar as claimant's current counsel has acknowledged the representation by prior counsel and has agreed that a portion of the CDA attorney fee proceeds should be paid to former counsel. Therefore, SAIF is directed to make the attorney fee of $7,475 payable to both claimant's former and current counsel.

Finally, we conclude that our decision to direct SAIF to pay both attorneys jointly will resolve this matter in the most expedient manner possible. If the attorneys continue to dispute the distribution of the fee, they may resolve their dispute through fee arbitration or in any other manner that they deem appropriate. This decision should not be interpreted as a decision that claimant's former counsel is, or is not, entitled to the entire amount of her claim for services. Rather, we are simply acknowledging that claimant's current counsel confirms that claimant's former counsel has rendered services for which she is entitled to a fee from the CDA proceeds (the specific amount of which will be resolved by them).

This claim disposition agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Therefore, this claim disposition agreement is approved. An attorney fee totaling $7,475, payable to both claimant's current and former counsels is approved.

IT IS SO ORDERED.

Board Chair Neidig specially concurring.

I agree with the majority that this CDA should be approved and that an attorney fee in the amount of $7,475 should also be approved. However, I do not agree with the majority's position that this case is similar to Ronald C. Kendall, supra. In Kendall, the current counsel not only agreed that the former counsel had represented the claimant on the CDA, the current counsel also agreed, with no objection from former counsel, that the fee could be distributed equally between the two attorneys. Furthermore, Kendall reiterated that the manner in which the fee is to be distributed between a current and former counsel is a matter to be decided between the two of them, not by the Board.

In this case, claimant's current counsel disagrees that certain services provided by former counsel were provided in relationship to the CDA. While claimant's current counsel has agreed to pay former counsel $1,200, current counsel also requests that former counsel's request for a $4,000 attorney fee be denied.

Consequently, because claimant's former counsel contends she is entitled to $4,000 from the attorney fee proceeds and claimant's current counsel is willing to concede to only $1,200, I would find that this matter is still in dispute. Our case law provides that when the attorneys' positions are in dispute, we will decline to determine the manner in which attorney fees shall be distributed. Fred L. Snider, 43 Van Natta 577 (1991). Under Snider, the attorney fee in this case should be approved payable to claimant's current counsel, the attorney of record, and any further disputes are a matter between claimant's counsels, not this forum.

In the Matter of the Compensation of
GINA M. McDONALD, Claimant
WCB Case Nos. 92-08952, 92-08306 & 92-06014
CORRECTED ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
H. Thomas Andersen (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

On April 14, 1994, we issued an Order on Review that affirmed Referee Black's order that: (1) concluded that Liberty Northwest Insurance Corporation's acceptance of claimant's 1988 injury claim for right hand tendonitis included claimant's current right carpal tunnel syndrome (CTS); (2) set aside Liberty's denial of the compensability of and responsibility for claimant's occupational disease claim for right CTS; (3) upheld the SAIF Corporation's "de facto" denial regarding the same condition on behalf of Jeff Kemp; (4) upheld SAIF's "de facto" denial regarding the same condition on behalf of Diane's Preschool and Day Care; (5) upheld SAIF's denial regarding the same condition issued on behalf of Rogue River Enterprises, Inc.; and (6) upheld SAIF's denial regarding the same condition as processing agent for Lois Whitehead Real Estate. It has come to our attention that our order contains a clerical error. Specifically, representing that the other parties have raised no objection, SAIF requests that we amend the language of "Footnote 3" to reflect what actually was said at hearing.

As stated in our order, Footnote 3 provides as follows:

> "At hearing, claimant's counsel stated that SAIF's counsel was prepared to orally deny the claim on behalf of Jeff Kemp and Diane's Preschool and Day Care. (Tr. 5). However, SAIF's counsel stated that he was 'not confirming that we deny on behalf of those employers that [claimant's] condition is compensable as to them.' (Tr. 6)." Order on Review at 7 n 3 (emphasis added).

SAIF asserts that the word "not", emphasized above, actually was "now". After examining the surrounding text of the transcript, and in light of the other parties' lack of opposition to SAIF's contention, we amend Footnote 3 in the following manner.

At hearing, claimant's counsel stated that SAIF's counsel was prepared to orally deny the claim on behalf of Jeff Kemp and Diane's Preschool and Day Care. (Tr. 5). SAIF's counsel confirmed that he had agreed to the oral denials. (Id.) The transcript reflects that SAIF's counsel then stated that he was 'not confirming that we deny on behalf of those employers that [claimant's] condition is compensable as to them.' (Tr. 6) (emphasis added). Taken in context, it is apparent that the word "not" actually was "now", and that SAIF's counsel was confirming SAIF's denials on behalf of those two employers.

Accordingly, we withdraw our April 14, 1994 order. On reconsideration, as supplemented and corrected herein, we republish our April 14, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD ROSS, Deceased, Claimant
WCB Case No. C4-00425
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewed by the Board en banc.

On February 15, 1994, 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's beneficiary releases certain rights to future workers' compensation benefits.

The parties' original agreement provided that claimant's beneficiary released her rights to surviving spouse benefits under ORS 656.204. The CDA provided that the beneficiary had been receiving surviving spouse benefits in the amount of $934.62 per month with claimant's surviving child receiving $150 per month. The CDA did not release the surviving child's benefits. However, claimant's beneficiary released her surviving spouse benefits for a total consideration of $23,205.60.

On March 10, 1994, the Board wrote to the parties to request further information. The Board requested the approximate present value of the beneficiary's survivor's benefits, documentation that claimant's beneficiary had been provided with the present value of the claim, and information regarding whether claimant's future benefits might be significantly altered in the future due to marriage. ORS 656.204(2).

On March 24, 1994, the Board received the insurer's letter stating that claimant's beneficiary had originally contacted the insurer concerning a CDA in an amount equal to the benefits she would be entitled to if she were to marry. The insurer informed the Board that the total indemnity estimate on the case at the present time was $196,127. The insurer had paid out $30,151.14, leaving a remaining total of $165,975.86. Of that amount, $38,000 remained in benefits for the surviving child, with $120,000 in benefits for claimant's beneficiary.

On April 14, 1994, the Board received a letter from claimant's beneficiary, expressing her intent to marry in July 1994. Claimant's beneficiary indicated that she wished to obtain approval of the CDA in order to pay her bills. Claimant's beneficiary further stated that she was aware of what she was giving up, yet she wished to proceed with the CDA.

After taking the beneficiary's April 14, 1994 correspondence into consideration, the Board finds that the CDA 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, hereby fully and finally resolving this matter.

In approving this CDA, however, it is noted that, prior to receipt of the beneficiary's correspondence indicating her intent to marry, a majority of this Board would have disapproved this agreement on the basis that it was unreasonable as a matter of law. ORS 656.236(1)(a); Louis R. Anaya, 42 Van Natta 1843 (1990)(A claim disposition agreement will be found unreasonable as a matter of law if it exceeds the bounds of existing statutes, rules or applicable case law, or if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact.).

The total consideration for the CDA was only equal to the amount claimant's beneficiary would have been statutorily entitled to should she choose to marry. See ORS 656.204(2)(c). Under such circumstances, we would have found the consideration, and therefore the CDA, to be unreasonable. In other words, claimant's beneficiary would have been releasing her future benefits for an amount that she could have received upon marriage without entering into a CDA. Consequently, given claimant's beneficiary's age and the present value of the claim, as a matter of law, a majority of the Board was prepared to disapprove the CDA on the ground that it was unreasonable as a matter of law.

However, as stated above, claimant's beneficiary has expressed an intention to marry within the next three months. Because the statute would terminate her benefits at that time, we now are convinced that the CDA may be approved as drafted.

IT IS SO ORDERED.

Board Members Neidig and Haynes, specially concurring.

We agree with the majority's decision to approve this CDA. However, we do not necessarily agree with the majority's position that, prior to the beneficiary's decision to marry, the amount of the CDA would have rendered the disposition unreasonable as a matter of law.

Our primary reason for contacting the parties in this case was to obtain an express statement from the beneficiary showing that she was clearly aware of the benefits being released. Although the parties' responses did not directly respond to our inquiry, we find that the beneficiary's decision to marry, and the majority's decision to approve the CDA on that basis, moots the need for further inquiry on this point.

However, we conclude that if the beneficiary could have shown that she was clearly aware of the benefits being released (which, in this case, as a survivor, rather than a claimant, were arguably of less value than the majority may believe), this CDA should have been approved as it was not unreasonable as a matter of law. The approach suggested by the majority is at variance with the Board's past review of CDA's, as it proposes a different standard than we have previously applied in our review.

In the present case, the majority has arrived at the conclusion that the CDA would have been unreasonable as a matter of law, due to the majority's belief that the amount was insufficient or unreasonable. However, such an analysis is subjective, rather than objective, and is contrary to our caselaw which requires a determination that a CDA be disapproved if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact (i.e., a reasonable fact-finder could only answer the question of fact in one way). By applying the standard in a subjective manner, the majority would disregard our own caselaw definition of "unreasonable as a matter of law." Louis R. Anaya, supra.

Finally, as noted above, we are not convinced that the amount of the CDA would have been unreasonable as a matter of law under any application of that standard. Although the majority emphasizes the "present value" of the claim, there is no recognition of the fact that in thirty years, a payment of $1,000 a month may be a truly nominal amount in comparison to a lump sum which the beneficiary could receive now. Additionally, claimant's beneficiary has stated from the outset that she wishes to settle this matter in order to pay her bills. In finding that the original amount would have been unreasonable, the majority ignores the true value of an expedient settlement for this beneficiary.

In the Matter of the Compensation of
SAMUEL J. ADAMS, Claimant
WCB Case No. 93-03309
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Phillip Nyburg (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Brown's order that: (1) upheld the insurer's denial of claimant's injury claim for a back strain; and (2) did not award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant worked as a choker setter for the insured. On the afternoon of February 12, 1993, during the course of his employment, claimant was struck on the head (probably by a tree limb) and knocked off his feet to the ground. Claimant was unconscious briefly. His hard hat was knocked from his head and his eyeglasses were askew. When he "came to," claimant's head hurt, he was dazed and dizzy, and he had blurred vision.

Three of claimant's co-workers, Mike Ring, Ted Stockton, and William Pitner, heard the sound of an object striking claimant's hard hat and observed claimant, who appeared stunned, on the ground. After a short time, claimant recommenced working until the end of the day, when he was laid off.

At first, claimant felt that his injury was not serious because he was able to continue working. However, as time went on, claimant's headache worsened. He complained of this to Ted Stockton on the way home that evening. Mr. Stockton advised claimant to go to the emergency room, which claimant did.

Dr. Stanford examined claimant, noted objective findings of injury, diagnosed a cervical and lumbar spine strain, and provided conservative treatment. On February 19, 1993, Dr. Stanford authorized time loss.

Claimant's neck symptoms resolved by February 26, 1993. However, Dr. Strietz examined claimant that day and authorized additional time loss based on claimant's continuing low back pain.

On March 22, 1993, the insurer denied claimant's claim for a musculoligamentous injury to the cervical and lumbar spine.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant failed to prove compensability, due to a perceived lack of objective findings supporting the claim and inconsistencies between claimant's reporting and the reporting of claimant's co-workers and doctors. We disagree.

Claimant bears the burden of proving that the February 12, 1993 accident at work was a material contributing cause of his subsequent disability and need for medical services. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a).

We note at the outset that the insurer does not dispute that claimant was hit on the head and knocked to the ground on February 12, 1993 during the course of his employment. Instead, the insurer contends that claimant filed this claim because he was laid off after the accident. We find no persuasive evidence supporting the insurer's position.

First, it is undisputed that claimant suffered immediate symptoms, some of which were visible to co-workers, following the accident. Second, claimant reported worsened symptoms to a co-worker that evening. Third, claimant promptly sought medical treatment. Fourth, there is no evidence that claimant had prior back problems or that this event could not have caused such problems. It is true that claimant did not promptly report the injury to the insured. However, considering the circumstances of the accident (including witnesses) and claimant's belief that his injury was not serious (because he managed to keep working), we conclude that the failure to promptly report the event does not weigh heavily against the claim. Accordingly, further considering the lack of factual complexity, we are persuaded that claimant's injury happened as he claims it did. See Barnett v. SAIF, 122 Or App 279 (1993).

We acknowledge the insurer's contention that claimant's reporting was inconsistent regarding details surrounding the February 12, 1993 event. For example, it is not clear whether claimant was standing on a stump when he was knocked out. It is similarly unclear whether the ground was level or sloping. In addition, it is unclear whether claimant was unconscious for a couple minutes or less than a minute. However, there is no showing that clarification of these details would impact the uncontroverted medical evidence relating claimant's back strain to the February 12, 1993 work accident. See Maria Gonzales, 46 Van Natta 466, 467 (1994) (A medical opinion is not unpersuasive due to an incomplete history, unless the omitted facts "have some bearing on the relevant issue.") (quoting Palmer v. SAIF, 78 Or App 151 (1986)).

Accordingly, considering the uncomplicated nature of the accident and the fact that conscious observers' accounts are materially consistent with claimant's reporting and the medical evidence, we conclude that claimant's work injury caused his subsequent disability and need for treatment for a back strain.

Finally, we find that the existence of claimant's back injury is clearly established by medical evidence supported by objective findings (see Exs. 1, 2, 9). See SAIF v. Cruz, 120 Or App 65 (1993); Georgia Pacific v. Ferrer, 114 Or App 471 (1992). Under these circumstances, we conclude that claimant has carried his burden under ORS 656.005(7)(a).

Penalties

The Referee awarded a penalty, based on the insurer's failure to pay interim compensation. The insurer does not contest this award.

Claimant requests an additional penalty based on the insurer's allegedly unreasonable denial, which states that there is "insufficient evidence" associating the injury with claimant's work exposure. (See Ex. 10). Claimant argues that the insurer issued its denial without proper investigation, only 30 days after receiving notice of the claim.

A penalty is assessable under ORS 656.262(10) when an insurer "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a denial must be gauged upon the information available to the insurer 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 insurer had a legitimate doubt regarding its liability for the claim. Id.

In our view, the "insufficient evidence" basis for the denial in this case is inconsistent with the uncomplicated mechanism of injury and the fact that three of claimant's co-workers heard the blow to claimant's hard hat and observed claimant lying on the ground immediately thereafter. Moreover, inasmuch as claimant sought medical treatment that day and no other cause is implicated, we cannot say that any doubt the insurer had about its liability was legitimate. Accordingly, we conclude that the denial was unreasonable and assess a penalty on that basis.

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 $3,600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (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 August 10, 1993 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's injury claim is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. That portion of the order that awarded a penalty of 25 percent of time loss due for the period between March 5, 1993 and March 22, 1993 is affirmed. In addition, the insurer is directed to pay an additional penalty of 25 percent of amounts due at the time of the hearing as a result of this order, excluding time loss for the period between March 5, 1993 and March 22, 1993, with one-half payable to claimant's attorney. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded a $3,600 attorney fee, payable by the insurer.

In the Matter of the Compensation of
CLINTON C. BUZZARD, Claimant
WCB Case No. 93-02257
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband, Hall and Haynes.

Claimant requests review of Referee Howell's order which upheld the self-insured employer's denial of claimant's current low back condition. In his brief, claimant argues, in the alternative, that his current condition is compensable as a consequential condition, or as an occupational disease. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On April 17, 1986, claimant compensably injured his low back. Over a period of four to five years, his claim was reopened and closed several times for aggravations. In April 1992, claimant suffered an exacerbation of his low back and leg symptoms. An MRI indicated foraminal encroachment and/or protrusion of disc material to the left of L5-S1 and lateral foraminal encroachment at L3-4 to the right side. (Ex. 53). An April 1993 MRI revealed an L5-S1 disc herniation.

Claimant worked for the employer until October 1992, when he was laid off. He had continued to experience low back and leg pain and, on October 29, 1992, Dr. Freeman, neurosurgeon, opined that claimant was a surgical candidate. On February 22, 1993, the insurer denied the surgery as not being compensably related to claimant's April 1986 injury.

The Referee concluded that claimant had failed to prove that his low back condition, which required surgery, was materially related to his compensable April 1986 low back injury. The Referee interpreted Dr. Freeman's April 14, 1993 report to indicate that claimant's lower extremity pain began immediately after the low back injury. Thus, the Referee believed that Dr. Freeman had an inaccurate history of claimant's injury and ensuing leg pain. We do not agree that Dr. Freeman's opinion should be rejected on that basis.

We interpret Dr. Freeman's statement that claimant had "an onset of low back pain progressing down both lower extremities, initiating in [sic] April 16, 1986" to mean that the pain subsequently progressed down both legs, not that the pain began at the time of the injury. (Ex. 80). When Dr. Freeman's opinion is read as a whole, we find this to be a reasonable interpretation of Dr. Freeman's use of the word "initiating" in his report.

Dr. Freeman stated that the disc herniation is consistent with the history of symptoms and the mechanism of injury described by claimant. Dr. Freeman further stated that the history of the injury and subsequent continuous exacerbations of low back and leg pain is consistent with herniations of L3-4 and L5-S1, "initiating" with the compensable injury in April 1986.

On April 30, 1994, Dr. Woolpert responded to a statement from the employer's attorney, stating that it was unlikely that the disc compromises related to claimant's initial 1986 strain injury. (Ex. 82-3).

When there is a dispute between medical experts, we give the most weight to those opinions that are well-reasoned. Somers v. SAIF, 77 Or App 259 (1986). Further, absent persuasive reasons to do otherwise, we generally give greater weight to opinions from the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983).

Here, we find no reasons not to defer to the opinion of claimant's treating neurosurgeon, Dr. Freeman. Dr. Woolpert's opinion, on the other hand, is merely a concurrence of an opinion written by the employer's attorney. After considering both opinions concerning causation of claimant's need for low back surgery, we are persuaded by Dr. Freeman's opinion that claimant's current disability and need for surgery is materially related to his April 1986 compensable low back injury.

The dissent contends, ostensibly on behalf of the employer, that in applying the material contributing cause test, we have applied the wrong standard of proof because the major contributing cause test under ORS 656.005(7)(a)(A) should be applied in this case. However, the parties, more importantly the employer, contend otherwise. According to the employer, "the sole issue before the Board is whether the surgery proposed by Dr. Freeman is materially related to the accepted 1986 low back injury claim." (Resp. Br. at 3). We have found that it is.

In light of the fact that we have reversed the Referee's opinion concerning compensability, we need not address claimant's arguments concerning alternative theories of compensability.

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 $5,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and reply brief, claimant's counsel's statement of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated July 8, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $5,000, to be paid by the self-insured employer.

Board Member Haynes dissenting:

For the following reasons, I respectfully dissent.

In order to prove compensability of his current need for low back surgery, claimant must establish either that his current condition and need for treatment were directly caused by the industrial accident (in which case, the material contributing cause standard applies) or that the current condition arose as a consequence of the compensable injury, which is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992). In this case, the issue before the Referee was whether claimant's disc problems were materially related to his April 1986 compensable industrial accident. (O & O at 4). Thus, claimant must prove, by a preponderance of the evidence, that his current herniated disc condition was directly caused by his industrial accident.

There is no question that claimant continued to experience periodic exacerbations of his 1986 injury, which the employer accepted as compensable aggravations. Nevertheless, I find no medical evidence of a material relationship between the need for low back surgery and the initial industrial accident. I agree with the Referee's conclusion that there is no medical evidence whatsoever that affirmatively, causally related claimant's disc condition to any "identifiable" event.

In support of their conclusion that a material causal relationship exists between the industrial accident and the current need for low back surgery, the majority apparently relies on "the record as a whole" and specifically, Dr. Freeman's opinion. (Ex. 80). Dr. Freeman, however, did not examine claimant for the first time until June 1992. Subsequently, he merely opined that claimant's herniated discs were consistent with the onset of symptoms and mechanism of injury, and that the 1986 industrial accident initiated the process, but the continuous exacerbations eventually contributed to the herniations.

In light of Dr. Freeman's opinion, I conclude that the majority has applied the incorrect standard of proof in this case. Because the evidence is uncontroverted that claimant's herniated discs did not occur at the time of his 1986 injury, claimant must prove, by a preponderance of the evidence, that his compensable injury is the major contributing cause of his current need for treatment. Gasperino, supra. Dr. Freeman's opinion is not sufficient to satisfy claimant's burden of proof.

With respect to the attorney fee for services at hearing and on Board review, claimant submitted a Statement of Services requesting $8,400; the Board, on its own motion, has granted $5,000. The Statement of Services did not provide any explanation concerning what claimant's attorney did to earn an $8,400 fee, but it indicated that 22 hours were billed at the contingency rate of $300, for an attorney with many years of experience, and 12 hours at the contingency rate of $150, for an attorney with two years of experience. The majority apparently considered those rates unreasonable, as I did. I would have awarded a fee of $2,000 for hearing and $1,000 on Board review.

Here, there was no objection from the employer concerning the amount of the attorney fee. However, this Board member will seriously consider any and all objections raised by the employer/insurer to claimants' counsels' Statement of Services. Claimants' attorneys' fees must be earned, and factual documentation from the employer/insurer in objection to claimants' counsels' Statement of Services will be heeded.

May 12, 1994 Cite as 46 Van Natta 919 (1994)

In the Matter of the Compensation of
CARL E. DODGE, Claimant
WCB Case No. 93-04471
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of that portion of Referee Garaventa's order which modified an Order on Reconsideration by awarding additional temporary total disability benefits for the period from February 18, 1991 through April 10, 1992. In his appellate brief, claimant also seeks penalties and attorney fees. On review, the issues are temporary disability benefits and penalties and attorney fees. We modify.

FINDINGS OF FACT

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

Claimant received unemployment compensation benefits during 1991 and 1992. (See Ex. 19; Tr. 21).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was totally disabled from working during the period from February 18, 1991 to April 10, 1992. On review, the insurer contends that, at best, claimant was only partially disabled during this period, and that the insurer is entitled to reduce claimant's temporary disability benefits as a result of unemployment benefits received during this period. See Appellant's Brief at 6. We agree.

Claimant received unemployment compensation during the period in question. Receipt of unemployment benefits demonstrates prima facie that claimant was able to work within the meaning of Unemployment Compensation Law, and such benefits may properly be treated as "post-injury wages" under the Director's rules regarding payment of temporary partial and total disability benefits. Wells v. Pete Walker's Auto Body, 86 Or App 739, 741-43 (1987); see also OAR 436-60-030 (WCD Admin. Order 94-050, temp. rule effective March 1, 1994). The insurer is entitled to reduce claimant's disability benefits for any period coinciding with his receipt of unemployment benefits. Wells, supra; Shirley J. Sanderson, 44 Van Natta 484 (1992). In his appellate brief, claimant agrees that the insurer is entitled to an offset for unemployment compensation received during the period in question.

Accordingly, we modify the Referee's order and the April 6, 1993 Order on Reconsideration. In lieu of the Referee's award of temporary total disability benefits, we award claimant temporary partial disability benefits for the period from February 18, 1991 to April 10, 1992. Temporary partial disability shall be calculated as provided in OAR 436-60-030 (WCD Admin. Order No. 94-050, temp. rule effective March 1, 1994).

In his appellate brief, claimant also seeks penalties and penalty-related attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation through its request for Board review. Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). If claimant believes that the insurer's request for review constitutes unreasonable conduct, it is claimant's option to request a new hearing on that issue. See Ronald L. Eagon, 44 Van Natta 2060 (1992). Claimant did not raise any penalty issues at hearing. Therefore, we decline to consider claimant's request for penalties and penalty-related attorney fees at this stage of our review. Alternatively, even if we considered this "post-Referee order" issue, we would not consider the insurer's conduct to have been unreasonable in light of our decision to modify the Referee's order.

Because we have reduced the compensation awarded to claimant by the Referee, he is not entitled to an insurer-paid attorney fee on review. See ORS 656.382(2).

ORDER

The Referee's order dated July 30, 1993 is modified. In lieu of the Referee's order which awarded temporary total disability benefits for the period from February 18, 1991 to April 10, 1992, we award claimant temporary partial disability benefits for the same period. The April 6, 1993 Order on Reconsideration is modified accordingly. Claimant's counsel's "out-of-compensation" attorney fee is likewise modified accordingly. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CHERYL A. HAMPTON, Claimant
WCB Case No. 92-11505
ORDER ON REVIEW
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Davis' order that affirmed an Order Suspending Compensation Pursuant to ORS 656.325 for failure to attend an independent medical examination. On review, the issue is suspension of compensation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact as supplemented in our "Conclusions of Law and Opinion."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant had refused to attend a medical examination on the insurer's behalf unless she was accompanied by a friend or family member, under OAR 436-60-085(1)(a) and OAR 436-10-100(6), the suspension order must be affirmed. On this record, we disagree.

We begin by briefly reviewing the pertinent facts. In September 1991, claimant slipped and fell at work. The insurer accepted a disabling contusion of the sacrum. Thereafter, the insurer asked claimant to attend a medical examination with Dr. Utterback, orthopedic surgeon. Claimant arrived at the doctor's office at the appointed time, accompanied by two friends and claimant's four-year-old son. One of the friends, a Mr. Thom, was to observe the examination and care for claimant's son; the other, a woman, was there to support claimant. The receptionist allowed claimant and her party to go into an examination room.

When Dr. Utterback arrived, he sternly (or, according to claimant, angrily) announced that anyone who wanted to remain in the examining room would have to remove his or her clothing. Claimant did not want her companions to leave, because she had been sexually assaulted in the past, and was nervous about being in a room alone with a male doctor. Claimant told Dr. Utterback that she

was nervous and that she wanted her companions to stay. Dr. Utterback responded that he would not examine claimant with anyone else present. Claimant called her attorney, and left the doctor's office without completing the examination.

Subsequently, the insurer discussed with Dr. Utterback his rationale for his policy of not permitting third persons to attend workers' compensation medical examinations. That rationale centered around Dr. Utterback's desire to obtain an accurate history and responses from the examinee, uninfluenced by other persons. (Ex. 28F).

The insurer sought an order from the Workers' Compensation Division (Division) suspending claimant's benefits for failure to attend a medical examination. In responding to the insurer's request, claimant's counsel asserted that, pursuant to the Division's rules, claimant had an absolute right to be accompanied by third persons during a medical examination. (Ex. 28E). Claimant's counsel did not mention the fact that claimant had been assaulted in the past, although he did note that claimant was nervous about the examination. (Id. at 2). The Division denied the request on the basis of various procedural irregularities. (Ex. 30-1). However, the denial order found that Dr. Utterback had the right to exclude claimant's friends from the examination and that claimant did not have a valid reason for terminating the examination. (Id.)

In the meantime, the insurer had scheduled a second medical examination of claimant on October 5, 1992, again with Dr. Utterback. (Ex. 28G). This time, claimant arrived at the doctor's office accompanied by her husband. Claimant advised the receptionist that she wanted her husband to attend the examination. The receptionist relayed that request to Dr. Utterback, who declined to examine claimant under those conditions. Again, the examination was not held.

Thereafter, at the insurer's request, the Division issued an Order Suspending Compensation Pursuant to ORS 656.325 as a result of claimant's refusal to submit to the second examination scheduled with Dr. Utterback. (Ex. 35). In objecting to the insurer's request, claimant's counsel essentially reiterated the reasons set forth in the objection to the insurer's original request for a suspension order. (Ex. 34). Additionally, counsel referred the Division to Tri-Met, Inc. v. Albrecht, 308 Or 185 (1989), in which the court held that a worker's insistence that his attorney be present during a medical examination to be performed on the carrier's behalf did not constitute obstruction of the examination sufficient to warrant suspension of the worker's rights to compensation.

Claimant timely requested a hearing to challenge the suspension order. At hearing, claimant testified that she had been sexually assaulted in the past. (Tr. 128, 141, 156). Her husband testified that, because claimant had been assaulted, he accompanied claimant almost everywhere she went to give her his support. (See Tr. 113). Mr. Thom, the friend who had accompanied claimant to the first scheduled examination, testified that claimant had told him that she did not want to be alone with Dr. Utterback because she had been assaulted. (Tr. 97).

ORS 656.325(1)(a) provides, in part:

> "Any worker entitled to receive compensation under this chapter is required, if requested by the director, the insurer or self-insured employer, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. * * * If the worker refuses to submit to any such examination or obstructs the same, the rights of the worker shall be suspended with consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period." (Emphasis added).

In Tri-Met, Inc. v. Albrecht, supra, the Supreme Court held that a worker's request to be accompanied by his attorney during an ORS 656.325(1)(a) medical examination did not constitute obstruction of the examination per se. When Albrecht issued, no administrative rules elaborated on how a worker can "refuse to submit" to or "obstruct" an ORS 656.325(1)(a) examination. See id., 308 Or at 189. Since then, the Director has prescribed several rules relating to that issue.

OAR 436-10-100(6) (amended by WCD Admin. Order 13-1992) provides:

> "The person conducting the examination shall determine the conditions under which the examination will be conducted. Subject to the physician's approval, the worker may use a video camera or tape recorder to record the examination. Also subject to the physician's approval, the worker may be accompanied, or remain accompanied, by a family friend or member during the examination. If the physician does not approve a worker's request to record an examination and/or allow the worker to be so accompanied, the physician must document the reasons." (Emphasis added).

OAR 436-60-085(1)(a) (amended by WCD Admin. Order 26-1990) provides, in part, that "[t]he conditions of the examination shall be consistent with the normal practices of the examining person and in compliance with these rules."

Those rules appear to give an examining physician the absolute right to refuse to allow a worker to record or to be accompanied during an examination, subject only to the requirements that the physician document his or her reasons for not complying with the worker's request, and that the conditions of examination comport with the physician's normal practices and the administrative rules. A further review of the rules reveals that that is not the case.

In addition to the language mentioned earlier, OAR 436-60-085(1)(a) provides that, when a worker has refused to submit to or has otherwise obstructed a medical examination, "[the] Compliance [Section] may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination." (Emphasis added). Similarly, OAR 436-60-095(4) (amended by WCD Admin. Order 26-1990) provides that, "[i]f a worker fails to attend or cooperate in a medical examination required to determine the nature or need for further treatment, without reasonable cause, any further treatment shall be suspended until the worker cooperates." (Emphasis added).

Reading together all of these rules, it is apparent that the Director intended to grant examining physicians exclusive authority to determine the conditions under which workers' medical examinations on behalf of carriers are to be conducted, subject to the requirements set forth in OAR 436-10-100(6) and OAR 436-60-085(1)(a). It is equally apparent that a worker's failure to comply with those conditions will justify the suspension of the worker's benefits until the worker is examined, unless the worker demonstrates that "special circumstances" or "reasonable cause" existed for the worker's failure to comply with the conditions of the examination. See OAR 436-60-085(1)(a); OAR 436-60-095(4).

Before we analyze whether there exist "special circumstances" or "reasonable cause" for claimant's failure to comply with Dr. Utterback's conditions of the examination, we note that, under OAR 436-60-085(1)(a), the Compliance Section is the entity designated to determine whether "special circumstances" exist that would not warrant suspension of a claimant's compensation for failure to attend or obstruction of an examination. (OAR 436-60-095(4), which sets forth the "reasonable cause" exception to the requirement that a claimant comply with a physician's conditions of examination, does not state which tribunal is to determine whether "reasonable cause" exists.) Therefore, it is arguable whether we should remand this case to the Compliance Section to determine if "special circumstances" exist.

Assuming that we have such remand authority, we conclude that we need not address that potential argument, because both the Referee and this Board have de novo review of orders suspending compensation pursuant to ORS 656.325 for failure to attend a medical examination. See Henry M. Granado, 42 Van Natta 846, 847 (1990). Accordingly, we conclude that, on the basis of the record developed at hearing, the Referee was entitled to consider whether "reasonable cause" or "special circumstances" existed for claimant's failure to comply with the conditions of the scheduled medical examination. Although the Referee did not consider that precise issue, we conclude that the record is sufficiently developed for our review. See ORS 656.295(5).

The record reveals that claimant did not comply with Dr. Utterback's policy of conducting medical examinations for workers' compensation carriers out of the presence of any third parties. However, the record also reveals that claimant's reason for not complying with that policy was her history of having been assaulted, which caused her to be nervous about being examined by an unattended, unfamiliar male physician. We conclude that, in this case, there clearly existed "special

circumstances" and "reasonable cause" for claimant's failure to comply with the conditions of the examination.[1] Accordingly, we reverse the Referee's order and set aside the Order Suspending Compensation Pursuant to ORS 656.325 for failure to attend an independent medical examination.[2]

ORDER

The Referee's order dated June 17, 1993 is reversed, and the Order Suspending Compensation Pursuant to ORS 656.325 for failure to attend an independent medical examination is set aside. Claimant's workers' compensation benefits are reinstated, effective October 26, 1992, the date of the suspension order. Claimant's counsel is awarded a fee in the amount of 25 percent of the increased compensation made payable by this order, not to exceed $3,800, to be paid by the insurer.

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[1] As a parenthetical note, we do not understand why the insurer did not to resolve this problem by scheduling claimant's second examination with another physician. Moreover, the record does not indicate why claimant's assault history was not disclosed to the insurer prior to hearing. Had claimant's examination been rescheduled with another physician, or her history been disclosed to the insurer at an earlier date, there may have been a possibility of avoiding this litigation altogether. The treatment that claimant and her associates received during the attempted examinations appears to us to have unnecesarily heavy handed.

[2] The suspension order states that

> "Dr. Utterback has appropriately documented his reasons for not allowing [claimant] to be accompanied by an additional person to the examination scheduled for October 5, 1992. These conditions are found to be consistent with Dr. Utterback's normal practices and in compliance with the administrative rules. Thus, [claimant] did not have a valid reason for failing to submit to the examination." (Ex. 35-1).

Because we have concluded that claimant did have a valid reason for failing to submit to the examination, we need not address the sufficiency of Dr. Utterback's documentation. We note, however, that the rules are unclear regarding when and to whom this documentation is to be issued. See OAR 436-10-100(6); see also OAR 436-60-085(1)(a).

May 12, 1994 Cite as 46 Van Natta 923 (1994)

In the Matter of the Compensation of
CHERYL L. HERRING, Claimant
WCB Case No. 93-04243
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee McCullough's order that: (1) declined to assess a penalty pursuant to ORS 656.262(10) or a penalty-related attorney fee pursuant to ORS 656.382(1) for allegedly unreasonable claim processing; and (2) declined to award an assessed attorney fee pursuant to ORS 656.386(1). On review, the issues are penalties and attorney fees.

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

Contending that the SAIF Corporation "de facto" denied her cervical condition, claimant seeks an attorney fee pursuant to ORS 656.386(1). Claimant also seeks penalties and related attorney fees for SAIF's allegedly late acceptance of claimant's cervical condition.

The Referee found that SAIF had not "de facto" denied claimant's claim. Rather, relying on SAIF v. Tull, 113 Or App 449 (1992), the Referee concluded that SAIF had accepted claimant's cervical condition. We agree. Applying Tull, we reach the factual determination that SAIF accepted the cervical condition pursuant to the parties' June 1990 stipulation.

Alternatively, assuming SAIF had "de facto" denied claimant's cervical condition, all compensation for claimant's cervical condition had been timely paid. Thus, there were no amounts then due upon which to base a penalty and no unreasonable resistance to the payment of compensation. See ORS 656.262(10); SAIF v. Condon, 119 Or App 194 (1993) (Holding that an insurer cannot unreasonably resist the payment of compensation that has been paid).

Finally, inasmuch as we agree with the Referee based on a factual determination that SAIF had accepted the cervical condition, we conclude that claimant's counsel was not instrumental in obtaining compensation for claimant. Thus, ORS 656.386(1) does not apply.

ORDER

The Referee's order dated July 15, 1993 is affirmed.

May 12, 1994 Cite as 46 Van Natta 924 (1994)

In the Matter of the Compensation of
THOMAS J. KAMINSKI, Claimant
WCB Case Nos. 93-14521, 93-14520 & 93-09324
ORDER OF DISMISSAL
Welch, Bruun, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney
John M. Pitcher, Defense Attorney
Scott Terrall & Associates, Defense Attorneys

The SAIF Corporation has moved the Board for an order dismissing SIMS' request for review on the grounds that not all of the parties received timely notice of SIMS' request. The motion is granted.

FINDINGS OF FACT

The Referee's Opinion and Order issued March 4, 1994. Parties to the hearing which resulted in the Referee's order were: claimant; Lincoln County and its insurer (SAIF); Weyerhaeuser Company; and Port of Newport and its claim processing agent (SIMS).

On April 4, 1994, SIMS mailed, by certified mail, its request for review of the Referee's order to the Board. The request included a certificate of service stating that a copy of the request had been mailed on April 4, 1994 to claimant's counsel. SIMS' request did not indicate that copies had been provided to Lincoln County and its insurer (SAIF), or to Weyerhaeuser Company.

On April 6, 1994, the Board mailed a computer-generated letter to the parties, acknowledging SIMS' request for Board review. That acknowledgment was received by SAIF and its attorney on April 7, 1994. Receipt of that acknowledgment constitutes SAIF's first notice of the request for review.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(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 March 4, 1994 order was April 3, 1994, a Sunday. Therefore, the final day to timely request review was Monday, April 4, 1994. Anita L. Clifton, 43 Van Natta 1921 (1991). Since SIMS' request was mailed by certified mail to the Board on April 4, 1994, it is timely. See OAR 438-05-046(1)(b).

However, the record fails to establish that all parties to the proceeding before the Referee were either provided with a copy, or received actual knowledge, of SIMS' request for review within the statutory 30-day period. Instead, based on SIMS' request for review and its accompanying certificate of service, the record does not establish that either Lincoln County and its insured (SAIF) or Weyerhaeuser were mailed a copy of SIMS' request.

Thus, this record establishes that Lincoln County / SAIF's and Weyerhaeuser's first notice of SIMS' request occurred when they each received a copy of the Board's April 6, 1994 computer-generated acknowledgment letter. Inasmuch as the final day for these opposing parties to receive timely notice of SIMS' appeal of the Referee's March 4, 1994 order was April 4, 1994, we find that notice of SIMS' request was not timely provided to all parties to this proceeding. Consequently, we lack jurisdiction to review the Referee's order. See ORS 656.289(3); 656.295(2); Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992); Argonaut Insurance Co. v. King, supra.[1]

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] SIMS acknowledges that it neglected to provide notice of its appeal to either Lincoln County, SAIF, or Weyerhaeuser. Notwithstanding this admitted omission, SIMS contends that such notice was unnecessary because it was not asserting that either of these employers (and their respective carriers) were responsible for claimant's claim. SIMS' position is contrary to law. As reasoned by the court in Mosley, a party to a referee's order remains a party for purposes of Board review and, as such, must receive timely notice of a request for review under ORS 656.295(2).

In the Matter of the Compensation of
RICKIE S. KROHNKE, Claimant
WCB Case No. 93-04481
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

On April 28, 1994, we withdrew our April 13, 1994 Order on Review which had reversed that portion of a Referee's order that directed the SAIF Corporation to recalculate the rate of claimant's temporary disability benefits and awarded an "out-of-compensation" attorney fee payable from those increased benefits. We took this action in response to the parties' announcement that they had resolved their dispute and would be submitting an agreement for our consideration. Having received the parties' stipulation, we proceed with our reconsideration.

The parties have submitted a proposed "Stipulation and Order," which is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders. Specifically, the parties agree that claimant shall receive additional temporary total disability totalling $7,500 ($750 of which shall be paid to claimant's attorney as an "out-of-compensation" fee).

We have approved the stipulation, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM S. PECKHAM, Claimant
WCB Case No. 92-15004
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Hazelett's order that upheld the insurer's partial denial of his current left knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

On July 1, 1992, claimant, who was employed as a delivery driver, slipped and fell several feet off a wet hydraulic tailgate to the ground, landing on his left knee. The emergency room diagnosed a contusion of the left knee. (Ex. 2-2). X-rays revealed no fracture or dislocation; calcification of the medial and lateral menisci was noted. Claimant was also diagnosed with a possible torn lateral meniscus. On July 10, 1992, Dr. Swanson noted that claimant's knee occasionally gave way. Claimant continued to work and his condition improved. (Ex. 2-3, 2-4, 4 and 6).

About the first of August 1992, claimant drove the employer's truck to Los Angeles and then returned to the Northwest. This truck, different from the one claimant drove at the time of injury, had a clutch. Claimant's knee pain returned and worsened with use of the clutch. (Tr. 8 and 17).

On September 8, 1992, Dr. Mysliwiec, orthopedic surgeon, examined claimant, who reported that walking and driving caused left knee pain, buckling and falls. Dr. Mysliwiec found a painful grind test of the patella with apparent contusion of its undersurface. He diagnosed chondromalacia, which he attributed to claimant's fall. He also found a positive McMurray sign for medial meniscus complaints and suspected a small tear of the medial meniscus. He noted that claimant had experienced multiple occasions of buckling and giving way of the left knee, sufficient to cause two falls. He attributed this buckling to the possible torn meniscus. He requested an arthrogram to verify whether claimant had a torn meniscus and a CT scan of the patella to look for a subluxing patella. He took claimant off work. (Ex. 9).

The left knee arthrogram revealed a short horizontal linear tear of the mid-portion of the medial meniscus. (Ex. 10). The CT scan of the patella revealed negative values bilaterally, confirming Dr. Mysliwiec's suspicion of chondromalacia of the undersurface of the patella. (Exs. 11 and 12). Dr. Mysliwiec requested authorization to perform an arthroscopic evaluation of claimant's left knee to examine the undersurface of the patella, patellar alignment, and the tear in the medial meniscus, with possible excision of the torn portion. (Ex. 12).

On October 14, 1992, Drs. Sears and Hogan performed a medical examination for the insurer. They diagnosed preexisting calcification of the medial meniscus, based on review of the earlier x-ray, and chondromalacia. They concluded that the chondromalacia was related to claimant's injury, but that claimant had no symptoms or findings consistent with a torn meniscus. They opined that claimant's severe symptoms were out of proportion to his disease process. They recommended against arthroscopic surgery. (Ex. 14). Dr. Mysliwiec did not concur with this report. (Ex. 17).

Claimant continued to have worsened knee pain. On October 22, 1992, Dr. Mysliwiec again requested arthroscopic surgery for the chondromalacia and the medial meniscus tear. (Ex. 15).

On October 30, 1992, the insurer accepted claimant's chondromalacia of the left knee. (Ex. 16).

On November 4, 1992, the insurer partially denied the preexisting calcification of the medial meniscus and refused to authorize surgery on the ground that it was necessitated as a result of the denied condition. (Ex. 18).

On November 20, 1992, Dr. Mysliwiec again requested authorization for arthroscopic surgery, essentially to diagnose the possible source of claimant's pain complaints, including the torn meniscus and the accepted chondromalacia condition. (Ex. 20). Dr. Sears recommended against the surgery for the symptoms of chondromalacia on the basis that it generally has a poor outcome, absent signs of abnormality, such as swelling of the knee. He recommended a program of quadriceps rehabilitation. (Ex. 21).

Dr. Mysliwiec reported that claimant continued to have pain in the antero-lateral aspect of the left knee and in the area superior to the patella, which was unresponsive to conservative treatment. He also reported that claimant fell when his left knee gave out, hurting his leg and back. He again requested authorization for the arthroscopic examination of the knee, based on claimant's failure to respond to all conservative methods of treatment, his continuous pain, falling, and buckling and giving way of the left leg because of the knee. (Ex. 21A).

CONCLUSIONS OF LAW AND OPINION

We note at the outset that claimant has been diagnosed with three left knee conditions: chondromalacia of the patella, which has been accepted by the insurer; preexisting calcification of the medial meniscus, which was denied by the insurer; and a medial meniscus tear. The Referee concluded that claimant had failed to prove that his current left knee condition was compensably related to his July 1992 industrial injury. We agree, but for different reasoning.

Preexisting Calcification of the Medial Meniscus

There is no evidence that any physician requested medical services for the preexisting calcification condition, nor is there any evidence that it combined with claimant's compensable injury. Nevertheless, claimant chose to litigate the merits of his "left knee condition" in its entirety and did not raise the issue of a premature denial of the preexisting calcification of the medial meniscus. Therefore, we address the merits of the denial of the calcification of the medial meniscus. See Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990).

The worker has the burden of proving a compensable injury or occupational disease. ORS 656.266. Here, given the multiple contributing factors in claimant's knee condition, we conclude that the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

There is no medical evidence that indicates that the calcification condition was either caused by or combined with claimant's compensable injury. Accordingly, we conclude that ORS 656.005(7)(a)(B) does not apply and that claimant has not sustained his burden of proving this condition is compensable.

Torn Medial Meniscus

Dr. Mysliwiec, claimant's treating orthopedic surgeon, diagnosed claimant with a torn medial meniscus, which was confirmed by an arthrogram. He requested authorization to perform an arthroscopic evaluation of claimant's left knee not only to examine the undersurface of the patella and patellar alignment, but to explore and possibly excise the torn medial meniscus. The insurer denied surgery on the basis that it was necessitated as a result of the denied preexisting calcification of the medial meniscus, a condition different from that for which the surgery request had been made.

However, because the surgery was requested for the torn medial meniscus, we treat the denial of surgery as a denial of the torn meniscus condition. Therefore, we proceed to determine whether the torn meniscus condition is compensable. The causation of this condition, like that of the calcification, presents a complex medical question requiring expert medical evidence to resolve. See Uris v. Compensation Department, supra; Kassahn v. Publishers Paper Co., supra.

Claimant contends that his current knee condition was caused by the original fall and his subsequent work for the employer. The record shows that claimant's knee initially improved after the fall. After he drove a truck, using a clutch, to Los Angeles and back, his knee worsened. However, the

medical record fails to identify the causal relationship, if any, between the compensable injury and the torn medial meniscus. Consequently, we conclude that claimant has failed to prove that his torn medial meniscus either arose, albeit belatedly, from the industrial accident itself, or is a condition that was caused in turn by the compensable injury. Thus, claimant has failed to carry his burden of proof under either the material contributing cause test applicable to a direct consequence of the industrial accident, see Albany General Hospital v. Gasperino, 113 Or App 411 (1992), or the major contributing cause test under ORS 656.005(7)(a)(A). Therefore, we conclude the torn medial meniscus is not compensable.

Because the reasonableness and necessity of the arthroscopic surgery for treatment of claimant's accepted chondromalacia condition was not raised at hearing, we do not address it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

ORDER

The Referee's order dated April 9, 1993 is affirmed.

Board Member Hall specially concurring.

I agree that the insurer's partial denial must be affirmed. However, because I do not believe that at-hearing amendments to denials should be permitted, I write separately.

Dr. Mysliwiec requested authorization for left knee surgery, in part, to examine the medial meniscus for tears and, if present, to excise the tears. The insurer denied the surgery request, contending that it was necessitated by the denied calcification condition. The insurer neither accepted nor denied the torn medial meniscus condition.

OAR 438-05-055 provides that "[i]n addition to the requirements of ORS 656.262, the notice of denial shall specify the factual and legal reasons for denial." In this way, the parties know exactly what issues to prepare to litigate. Further, the Court of Appeals held in Tattoo v. Barrett Business Services, 118 Or App 348, 351 (1993), that "employers are bound by the express language of their denials."

The Tattoo holding prohibits an insurer from making oral amendments to denials at hearing. Such amendments, I believe, are distinguishable from pre-hearing amendments to the hearing request, which are expressly permitted by OAR 438-06-031.

In this case, I would ordinarily conclude that the insurer was prohibited from orally amending its denial at hearing to deny the torn medial meniscus. However, it appears from this record that claimant chose to proceed on that issue (Tr. 2) and, thus, waived a procedural challenge to the denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432 (1990).

On this record, therefore, it was proper to proceed to the issue of compensability of the torn medial meniscus. Because the issue presents a complex medical question and there is no medical evidence in the record to resolve the question, I also conclude that claimant has not sustained his burden of proof.

In the Matter of the Compensation of
VELMA L. VETTERNACK, Deceased, Claimant
WCB Case No. 93-06051
ORDER ON REVIEW (REMANDING)
Francesconi & Busch, Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant, through her personal representative, requests review of Referee Galton's order that declined to award unscheduled permanent partial disability for her psychological condition. On review, the issue is extent of unscheduled permanent disability. We remand.

FINDINGS OF FACT

On May 19, 1988, claimant sustained a compensable injury to her left leg that resulted in amputation below the knee.

On November 11, 1992, claimant was killed in an accident unrelated to her work.

On February 5, 1993, claimant's claim was closed by Determination Order, which awarded temporary disability and 100 percent scheduled permanent disability for the loss of her lower left leg. (Ex. 4).

On April 19, 1993, an Order on Reconsideration issued, modifying claimant's scheduled permanent disability award to 91 percent for the left leg and declining to award unscheduled disability for her psychological condition. (Ex. 5).

On May 24, 1993, the attorney retained by claimant's personal representative requested a hearing. The hearing was held on August 18, 1993.

CONCLUSIONS OF LAW AND OPINION

Pursuant to our de novo review authority, we note that the record contains no evidence as to whether a statutory beneficiary exists to continue claimant's claim for benefits. ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596, 600 (1986).

Survival of actions in workers' compensation cases is governed strictly by statute. See Majors v. SAIF, 3 Or App 505 (1970); Charlotte Kuklhanek, 37 Van Natta 1797, 1698 (1985). ORS 656.218(2). If, as here, death occurs prior to filing a request for hearing, the persons described in ORS 656.218(5) shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing. ORS 656.218(4).

The persons entitled to pursue the matter are those "who would have been entitled to receive death benefits if the injury causing the disability had been fatal." ORS 656.218(5). Death benefits are payable to the worker's surviving spouse, children under the age of 18 years, or the worker's "dependents." ORS 656.204(2), (4) and (5). Pursuant to ORS 656.005(10), "dependent" refers to a series of relatives of the deceased worker "who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker."

A personal representative lacks authority to claim benefits on behalf of a deceased claimant. Trice v. Tektronix, 104 Or App 461, 465 (1991). Here, the record fails to establish that claimant was survived by an individual who would be entitled to pursue the claim.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Because the resolution of the issue of whether a statutory beneficiary exists to continue claimant's claim for benefits is a prerequisite to survival of the claim, and because we are unable to ascertain this information from the record as presently constituted, we conclude that the record has been incompletely developed.

Accordingly, we vacate the Referee's order dated August 20, 1993 and remand this matter to Referee Galton with instruction to reopen the record for the limited purpose of admitting additional evidence regarding whether a statutory beneficiary exists to continue claimant's claim. The Referee is further instructed to proceed in any manner that that will achieve substantial justice. ORS 656.283(7). The Referee shall then issue a final, appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated August 20, 1993 is vacated. The matter is remanded to Referee Galton for further proceedings consistent with this order.

May 13, 1994 Cite as 46 Van Natta 930 (1994)

In the Matter of the Compensation of
KAREN M. COLERICK, Claimant
WCB Case No. 92-10469
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Nichols' order which upheld the insurer's denial of claimant's psychological claim. On review, the issue is compensability.

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

In evaluating claimant's psychological claim, the Referee found that the majority of claimant's stressors were the result of reasonable disciplinary, corrective or job performance evaluation actions by the employer or due to the termination of employment. See ORS 656.802(3)(b). The Referee, therefore, determined that they could not be considered in evaluating whether or not employment conditions were the major contributing cause of claimant's mental disorder. Reasoning that the medical evidence was insufficient to establish that other employment stressors were the major contributing cause of claimant's mental disorder, the Referee upheld the insurer's denial of the psychological claim.

On appeal, claimant concedes that the Referee properly applied ORS 656.802 if the stress causing claimant's mental condition resulted from the employer's disciplinary actions that eventually led to termination of her employment. Claimant contends, however, that job stress and her reaction to it led to the employer's perceived need to discipline claimant. Claimant cites stress from changes brought about by a new administration at the nursing home in which she was employed as causing her mental disorder.

However, based upon the facts in this case, we find that the conditions that claimant cites, i.e., changes in procedures, turnover in personnel, understaffing, altered job descriptions and decreased patient care, constitute conditions generally encountered in every working situation. See ORS 656.802(3)(b). Accordingly, in this case, they are excluded from consideration in determining whether or not employment conditions are the major contributing cause of claimant's mental disorder. See Lynn A. Horton, 45 Van Natta 2203, 2204 (1993). Moreover, even if they were not excluded from consideration, the medical evidence does not establish that these conditions, as opposed to stressors resulting from reasonable disciplinary, corrective or job performance evaluation actions or cessation of employment, are the major contributing cause of claimant's psychological condition. (See Exs. 31, 37, 37A, 40, 42, 43).

Finally, claimant contends that she suffered physical disability as a result of job stress. She asserts that it is compensable regardless of whether the stress was caused by reasonable disciplinary, corrective or job performance evaluation actions or cessation of employment. Claimant is incorrect. As the insurer notes, any claim that a condition is independently compensable as a result of job stress, regardless of whether the condition is mental or physical, is subject to the requirements of ORS 656.802. SAIF v. Hukari, 113 Or App 475, 480 (1992), rev den 314 Or 391 (1992).

ORDER

The Referee's order dated July 22, 1993 is affirmed.

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case Nos. 91-11547 & 91-11151
SECOND ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

On April 21, 1994, we withdrew our March 24, 1994 Order on Remand that affirmed a Referee's order which increased claimant's scheduled permanent disability award from 12.75 percent for left ear hearing loss to 44.53 percent for binaural hearing loss. We took this action to consider the self-insured employer's objections to several evidentiary rulings made in our decision. Having received claimant's response, we proceed with our reconsideration.

The relevant facts are as follows. Approximately 5 1/2 years after claimant began his employment, his employer's personnel records contained an entry regarding claimant's decibel levels from an audiogram which was allegedly conducted shortly before his employment. When claimant eventually suffered compensable bilateral hearing loss and his disability was evaluated, the self-insured employer sought to offset his loss by his preexisting hearing loss.

We held that, in determining whether claimant's hearing loss may be offset by hearing loss which preexisted his work exposure, the decibel level reference in the employer's business records was not adequate documentation by a pre-employment audiogram as required by OAR 436-35-250(2). Consequently, we declined to apply an offset for preexisting hearing loss.

We acknowledged that there was evidence that claimant had experienced preexisting hearing loss. We further noted the entry in the employer's personnel records showed claimant's decibel levels some 5 1/2 years prior to the entry (when claimant began his employment). Nevertheless, we did not consider that the "numbers" alone constituted a "pre-employment audiogram" as expressly required by the rule. Finally, we noted that there was no testimony that such a pre-employment test was conducted (in fact, claimant had testified that his pre-employment physical did not include a hearing test). In light of such circumstances, we concluded that a preexisting hearing loss was not adequately documented by a pre-employment audiogram as required by OAR 436-35-250(2).

The employer raises several objections to our decision. Those objections are as follows: (1) our reliance on the opinion of Dr. Tate for proving hearing loss attributable to claimant's employment was misplaced; (2) claimant "sabotaged" the hearing test performed by the medical arbiter; (3) we erroneously refused to apply an offset for preexisting hearing loss; and (4) our deference to Dr. Tate as an attending physician was inappropriate.

After consideration of the employer's contentions, we continue to adhere to our ultimate conclusion that claimant is entitled to the binaural hearing loss award granted by the Referee's order. However, we offer the following supplementation in response to the employer's arguments.

To begin, the employer asserts that we incorrectly declined to consider the opinion of an examining physician for purposes of impeaching the impairment findings rendered by the attending physician. We disagree with that assertion.

As explained in our decision, the court has held that ORS 656.245(3)(b)(B) does not recognize the distinction between offering an examining physician's impairment findings for impeachment rather than as proof of a carrier's factual contention regarding the extent of impairment. Koitzsch v. Liberty Northwest, 125 Or App 666 (1994). Consequently, the court has ruled that such "examiner's" findings, regardless of whether or not offered for impeachment are, nonetheless, findings regarding the worker's impairment and, as such, violate the statutory requirement that only the attending physician make such findings. Koitzsch, supra.

The employer's "sabotage" argument is apparently based on the report from the medical arbiter (Dr. Springate) that claimant's responses to pure tone tests were inconsistent and did not coincide with prior tests. Notwithstanding these inconsistent results, Dr. Springate also acknowledged that claimant's previous hearing tests were quite consistent and provided an accurate reflection of claimant's hearing loss. Based on those results, Dr. Springate opined that claimant's hearing loss was unrelated to work exposure and probably inherited. This opinion was essentially shared by another physician, Dr. Ediger.

In the absence of further substantiation or corroboration, the aforementioned reference to inconsistent test results does not establish that claimant "sabotaged" his hearing test with the medical arbiter. In any event, such results did not preclude the arbiter (Dr. Springate) from issuing an opinion based on claimant's prior tests which the arbiter considered to be quite consistent. That opinion, as well as an opinion from another examining physician (Dr. Ediger), supported the employer's contention that claimant's hearing loss was not work-related.

As detailed in our decision, the opinions offered by the arbiter and the other examining physician (Dr. Ediger) were fully considered. However, for the reasons expressed in our order, we declined to rely on those physicians' conclusions. Inasmuch as those reasons were not based on any inconsistent test results ("sabotaged" or otherwise), we do not agree with the employer's contention that the arbiter's examination and report were "invalidated." Rather, as explained in our prior decision, the opinion of Dr. Tate was considered to be more persuasive.

The employer challenges our reliance on Dr. Tate as an "attending physician," noting that Dr. Tate had also examined claimant on only one occasion. Since Dr. Tate did not have any greater opportunity to observe and evaluate claimant than the other examining physicians, we acknowledge that our reliance on Dr. Tate's opinion on that basis was unsound. Nonetheless, as explained in our decision, this basis was not the sole reason for our reliance on Dr. Tate's opinion.

Specifically, we discounted Dr. Ediger's opinion due to the speculative reference to the "possibility" of ear disease. Likewise, we considered Dr. Springate's conclusion that heredity was a causal factor to be unexplained. Finally, in contrast to Dr. Tate's opinion, we found both opinions to be unpersuasive because of their reliance on "preexisting hearing loss" which was not adequately documented by a pre-employment audiogram as required by OAR 436-35-250(2)(a).

As a final matter, the employer objects to our "hypertechnical approach to the consideration of evidence." In other words, the employer contends that we have inexplicably refused to consider its business record which contained an entry to claimant's pre-employment audiogram. We disagree with the employer's characterization of our conclusion.

As discussed in our decision, preexisting hearing loss may be offset against a worker's hearing loss provided that the preexisting loss is "adequately documented by a pre-employment audiogram." OAR 436-35-250(2)(a). Inasmuch as this rule is a standard for evaluating disability adopted by the Director under ORS 656.726, we must apply it. See ORS 656.295(5).

Therefore, although the employer's business record is certainly admissible as evidence, its probative weight is seriously diminished. As previously explained in our order, with the exception of the 1981 reference to decibel levels in the employer's business record, there is no evidence documenting a 1975 pre-employment audiogram. In fact, not only was there no testimony presented to confirm that such a pre-employment test was conducted, but claimant testified that his pre-employment physical did not include a hearing test. In light of such circumstances, we continue to conclude that an offset for preexisting hearing loss is not warranted under OAR 436-35-250(2)(a).

Claimant's attorney is also entitled to a carrier-paid attorney fee for services on reconsideration. 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 reconsideration is $175, 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 response), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented herein, we republish our March 24, 1994 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
ORVAL R. OGBIN, Claimant
WCB Case No. 92-14350
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

On April 21, 1994, we withdrew our March 24, 1994 Order on Review that affirmed a Referee's order that awarded 44.53 percent (85.50 degrees) scheduled permanent disability for binaural hearing loss, whereas an October 30, 1992 Order on Reconsideration had declined to award scheduled permanent disability. We took this action to consider the self-insured employer's objections to several evidentiary rulings made in our decision. Having received claimant's response, we proceed with our reconsideration.

This date, we have issued a Second Order on Remand, which addresses the employer's contentions. Orval R. Ogbin, 46 Van Natta 931 (1994). By this reference, we incorporate into this order the reasoning and conclusions contained in that order.

Claimant's attorney is also entitled to a carrier-paid attorney fee for services on reconsideration. 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 reconsideration is $175, 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 response), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented herein, we republish our March 24, 1994 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
KATHRYN A. WHITMORE-TRIBE, Claimant
WCB Case No. 93-05979
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Bethlahmy's order that affirmed the Order on Reconsideration which awarded her 20 percent (30 degrees) scheduled permanent disability for the loss of use or function of the left leg (knee) and 8 percent (12 degrees) scheduled permanent disability for the loss of use or function of the right leg (knee). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the finding that claimant does not have a chronic condition limiting repetitive use of the right knee.

CONCLUSIONS OF LAW AND OPINION

In calculating the extent of claimant's scheduled permanent disability for both legs, the Referee found that claimant does not have either a chronic condition limiting repetitive use of the right knee or left knee joint instability. On review, claimant contests both findings and requests an additional scheduled award for both legs.

We agree with and adopt the Referee's conclusions and opinion regarding the absence of persuasive medical evidence establishing left knee joint instability.

However, we do find sufficient medical evidence establishing a chronic condition limiting repetitive use of the right knee. Claimant became medically stationary as of December 9, 1992. (Exs. 7-8, 40-1). Thereafter, Dr. Gerry examined claimant and reported that she has a "chronic condition leaving her unable to repetitively use her right knee." (Ex. 42-2). Dr. Benz, claimant's attending physician, concurred with Dr. Gerry's report. (Ex. 43). Given that concurrence, Dr. Gerry's report may be considered for purposes of rating claimant's permanent impairment. See former OAR 436-35-007(8); Kathy Bott, 44 Van Natta 2366 (1992).

The Referee reasoned, and the self-insured employer argues on review, that Dr. Gerry's opinion is unpersuasive because it is conclusory and is inconsistent with other medical evidence in the record. We disagree.

Although Dr. Gerry did not explain his opinion, we find that his report is sufficiently persuasive to support a chronic condition award because there is no medical evidence to the contrary. The Referee and the employer noted that Dr. Benz had opined in his closing report that claimant's right knee problems were "not of a surgical nature." (Ex. 7-8). The fact that the right knee does not require surgery, however, is not necessarily inconsistent with a finding of a chronic condition limiting repetitive use of the knee. Moreover, subsequent to issuing his closing report, Dr. Benz concurred with Dr. Gerry's findings and did not indicate any disagreement with the chronic condition finding. Under these circumstances, we find that claimant has proved a chronic condition which renders her unable to repetitively use the right knee.

Therefore, claimant is entitled to an additional 5 percent scheduled permanent disability award, giving her a total scheduled award of 13 percent for loss in the right knee. We modify the Referee's order accordingly.

ORDER

The Referee's order dated September 13, 1993 is modified in part and affirmed in part. The Order on Reconsideration is modified to award an additional 5 percent (7.5 degrees) scheduled permanent disability for the right leg, giving claimant a total scheduled permanent disability award of 13 percent (19.5 degrees) for the right leg (knee) and 20 percent (30 degrees) for the left leg (knee). Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to the attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LORI A. AUTERSON, Claimant
WCB Case No. 93-04323
ORDER ON RECONSIDERATION
Estell & Bewley, Claimant Attorneys
VavRosky, et al., Defense Attorneys

On April 15, 1994, we affirmed a Referee's order that: (1) denied claimant's request for a penalty and attorney fee for the self-insured employer's alleged "de facto" denial of claimant's cervical and right shoulder strain injury claim; and (2) declined to assess an attorney fee pursuant to ORS 656.386(1). We have now received a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter, as well as those issues which are presently pending before the Hearings Division. (WCB Case Nos. 93-08831 & 92-14724). Those portions of the agreement which pertain to the Hearings Division have received Referee approval.

We treat this submission as a motion for reconsideration of our April 15, 1994 order. Consequently, we withdraw our prior order and proceed with this reconsideration.

Pursuant to the settlement, claimant agrees "to take no further appeal of the [Board's] April 15, 1994 Order on Review." We have approved those portions of the parties' agreement which pertain to this case, thereby fully and finally resolving this dispute.

Accordingly, on reconsideration, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROCHELLE M. COLLINGE, Claimant
WCB Case No. 93-03713
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Thye's order that set aside its "de facto" denial of claimant's aggravation claim for a right ankle condition. On review, the issue is aggravation.

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

The Referee found that claimant proved her aggravation claim based in part on a finding that claimant's worsened right ankle symptoms resulted in diminished earning capacity. Instead, we find that an aggravation of claimant's scheduled injury is established by increased loss of use or function of claimant's right ankle. See Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993).

In addition, we find that claimant perfected her aggravation claim by January 7, 1993, when the insurer received Dr. Neitling's December 21, 1992 chart note, (Ex. 13; see Ex. 12). See Herman Carlson, 43 Van Natta 963, 964 n.1 (1991), aff'd on other grounds, Carlson v. Valley Mechanical, 115 Or App 371 (1992), rev den 315 Or 311 (1993). Thus, the insurer was required to except or deny the claim within 90 days of January 7, 1993. See ORS 656.262(6).

Claimant requested a hearing from the insurer's alleged "de facto" denial of this claim on March 29, 1993, less than 90 days after notice of the claim. See ORS 656.262(6); Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). However, the insurer raised no objection to consideration of the claim at hearing. Under these circumstances, the insurer's failure to object constituted "denial of the claim and a valid waiver of all procedural errors relating to litigation of the claim." Thomas v. SAIF, 64 Or App 193 (1983).

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 $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 31, 1993 is affirmed. For services on review, claimant's counsel is awarded a $500 attorney fee, payable by the insurer.

May 16, 1994 Cite as 46 Van Natta 936 (1994)

In the Matter of the Compensation of
TOM GOODPASTER, Claimant
WCB Case No. 92-15201
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Bethlahmy's order which set aside its denial of claimant's occupational disease claim for a psychological condition. Claimant cross-requests review of that portion of the Referee's order which awarded a $4,000 insurer-paid attorney fee. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

We adopt and affirm that portion of the Referee's order which pertains to the compensability of claimant's psychological condition. We modify the Referee's attorney fee award under ORS 656.386(1).

The Referee awarded claimant's counsel $4,000 at hearing. Claimant contends that the award should be increased. In support of his contention, claimant has provided his attorney's statement of service which seeks a $7,656.50 fee for 50.85 hours of attorney time and 15.1 hours of investigator time.

In determining a reasonable attorney fee under ORS 656.382(2), 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 attorney; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. "Costs," which are moneys expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, are not included in attorney fee awards. OAR 438-15-005(6).

Our review of the record reveals the following information. The file contains two reports from claimant's treating physician, Dr. Johnson, which were solicited by claimant's counsel (Exs. 12 & 13), a deposition of Dr. Parvaresh, which was attended by claimant's attorney (50 pages), (Ex. 11), and the transcript of a two day hearing (203 pages) during which seven witnesses testified. (Ex. 16).

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 is $6,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted by claimant's attorney to the issue (as represented by the hearing record and by claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have not considered claimant's attorney's investigator's time since such efforts represent claimant's attorney's costs incurred in pursuing the case on claimant's behalf. OAR 438-15-005(6).

Inasmuch as claimant did not file a brief on review, he is not entitled to an assessed attorney fee, under ORS 656.382(2), for prevailing over the SAIF Corporation's request for review. Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The Referee's order dated November 4, 1993 is modified in part and affirmed in part. In lieu of the Referee's attorney fee award, claimant is awarded an assessed attorney fee of $6,000, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

May 16, 1994 Cite as 46 Van Natta 937 (1994)

In the Matter of the Compensation of
LILLIAN K. JOHNSON, Claimant
WCB Case No. 93-07666
ORDER ON REVIEW
Allen, Stortz, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that set aside its denial of claimant's occupational disease claim for her bilateral carpal tunnel disease condition. On review, the issue is compensability.

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

On review, SAIF argues that the Referee did not provide any reason for rejecting the opinion of Dr. Radecki, M.D. Dr. Radecki acknowledged that claimant had a carpal tunnel condition. However, he concluded that, after reviewing video tapes of claimant's job, he found no evidence that claimant was doing any repetitive flexion or extension of the fingers and wrist.

Under the circumstances, we conclude that Dr. Radecki's opinion is not persuasive for the same reasons the Referee found Dr. Button's opinion not persuasive. In other words, it has not been established which videotape Dr. Radecki observed in arriving at his opinion. Additionally, the videotape received into evidence did not fully depict all of claimant's job duties and claimant's credible testimony varied from Dr. Radecki's description of her job.

Finally, Dr. Radecki reasoned that claimant's carpal tunnel condition was a "familial trait," even though only one other individual in claimant's family (one of her four siblings, who worked as a boilermaker) had ever had carpal tunnel disease. Furthermore, Dr. Radecki found that claimant was approximately 25-30 pounds over her ideal weight, yet he believed that medical literature supported an increased incidence of carpal tunnel when one passed from "slender to obese." Without further explanation, we are not persuaded by Dr. Radecki's opinion attributing claimant's carpal tunnel disease to a "familial trait," or to an "obese" weight condition. Accordingly, we conclude that Dr. Radecki's opinion should be discounted.

Claimant is entitled to an assessed attorney fee for successfully defending against SAIF's request for review on the carpal tunnel condition issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated October 25, 1993 is affirmed. For services on review concerning the carpal tunnel condition, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MICHAEL J. ROCHEL, Claimant
WCB Case No. 93-01344
ORDER ON REVIEW
Parker, et al., Claimant Attorneys
Craig Creel, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Peterson's order which set aside its denial of claimant's aggravation claim for his current low back condition. On review, the issue is aggravation.

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

At hearing, the only issue before the Referee was the insurer's January 18, 1993 denial, which denied claimant's aggravation claim on the basis that claimant's current condition was due to an off-work injury.

Here, claimant has the burden of proving that the compensable 1990 injury is a material contributing cause of his worsened low back condition. Additionally, because the insurer has denied the aggravation claim on the ground that an off-the-job injury is the major contributing cause of the worsened condition, the insurer has the subsequent burden of proof of establishing that an injury not occurring within the course and scope of employment was not the major contibuting cause of the worsened condition. See ORS 656.273(1). Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992).

Here, we agree with the Referee that the opinion of Dr. Markham, claimant's treating neurologist, establishes that claimant's compensable 1990 injury is a material contributing cause of his worsened low back condition. Furthermore, although Dr. Markham originally found that claimant's symptoms were related to the off-work incident of November 10, 1992, he later clarified that the incident was "very minor," as claimant was only carrying 10 pounds. Dr. Markham stated that claimant's low back problem dated to the compensable injury when claimant was unloading 75-pound pallets. Dr. Markham concluded by reporting that he put "very little weight as to causation on the November 10, 1992 injury."

Under the circumstances, we agree that the Referee properly relied on the opinion of claimant's treating physician, and we conclude that the insurer has failed to establish that an off-work injury was the major cause of claimant's worsened low back condition. We, therefore, affirm the Referee on the issue of aggravation.

Claimant is entitled to an assessed attorney fee for successfully defending against the insurer's request for review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated November 1, 1993 is affirmed. For services on review, claimant's counsel is entitled to an assessed attorney fee of $600, to be paid by the insurer.

In the Matter of the Compensation of
LLOYD S. ABRAHAM, Claimant
WCB Case No. 92-14829
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
James W. Moller (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our March 24, 1994 Order on Review that: (1) found that the Referee had jurisdiction over claimant's timely request for hearing from SAIF's aggravation denial; and (2) affirmed the Referee's order setting aside SAIF's denial of claimant's aggravation claim for a low back condition. Specifically, SAIF requests reconsideration for three reasons: (1) to clarify the nature of its argument concerning claimant's failure to perfect a claim for aggravation; (2) to point out factual errors in our prior order; and (3) to challenge the "waxing and waning" (aggravation) issue on the merits.

In order to further consider SAIF's contentions, on April 15, 1994, we abated our March 24, 1994 Order on Review and granted claimant an opportunity to respond to SAIF's motion. Having received claimant's response, we proceed with our reconsideration.

Claim Filing/"Perfection"

SAIF contends that it did not intend to assert on review that the Referee "lacked jurisdiction to address the aggravation issue." Instead, SAIF contends, it intended only to raise the issue of whether claimant had "perfected" an aggravation claim. SAIF argues that claimant's failure to "perfect" an aggravation claim made it impossible for SAIF to process the claim timely, and that the Board's analysis (which focused on jurisdiction rather than on whether claimant "filed" an aggravation claim) restricted SAIF from denying the claim as "improperly and ineffectively perfected."

SAIF argues that, despite its aggravation denial, it is entitled to contend that claimant did not make an aggravation claim that satisfies the filing requirements of ORS 656.273(2) (to obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer). We agree that the issuance of a denial is not controlling as to whether an aggravation claim was filed nor does it preclude an insurer from arguing that a claimant did not "perfect" an aggravation claim. We did not intend to suggest otherwise in our prior order. Therefore, we clarify that the fact that SAIF issued an aggravation denial does not preclude it from contesting whether claimant actually filed an aggravation claim. Rather, whether claimant filed an aggravation claim is a question of fact.

As a practical matter, however, the issuance of such a denial is probative evidence concerning whether an aggravation claim has been presented to an insurer. Here, claimant forwarded to SAIF chart notes and a work release slip from Dr. Mitchell, his attending physician, as well as a May 5, 1992 letter requesting payment of temporary disability. SAIF treated those written submissions as an aggravation claim and issued a denial on October 16, 1992, advising claimant that "there is no medical evidence your condition has worsened since the last award or arrangement for compensation." In light of such circumstances, we find that claimant submitted an aggravation claim to SAIF which satisfied the filing requirements of ORS 656.273(2).

Moreover, we continue to conclude that SAIF's issuance of a denial conferred jurisdiction on the Referee to reach the merits of the aggravation issue. See ORS 656.319(1); Morelock Wood Products v. Baur, 105 Or App 371 (1991) (a claimant's timely request for hearing from an insurer's denial vests jurisdiction in the Board and its Hearing Division).

Finally, we do not agree that claimant's alleged failure to "perfect" an aggravation claim made it impossible for SAIF to process the claim timely. Until such time as claimant properly filed an aggravation claim, SAIF was under no obligation to issue a denial. See ORS 656.273(3),(6); Herman M. Carlson, 43 Van Natta 963 (1991). In any event, the issue on Board review was compensability, not penalties for allegedly untimely claims processing. The "timeliness" of SAIF's denial was not considered.

Factual Matters

SAIF argues that the Board's statement that "[n]o party suggested that the claim was prematurely closed [.]" is inaccurate because claimant argued premature closure in seeking reconsideration of the Determination Order. We disagree. Although the order may have recited that claimant contended that his claim was closed prematurely, the record clearly demonstrates that claimant did not raise premature closure as an issue on the Request for Reconsideration form. Moreover, even if we were to agree that the finding was in error, SAIF has not explained the significance of this "error." As SAIF acknowledges, claimant did not raise premature closure as an issue at hearing or on Board review. Neither was this issue considered by the Referee or by the Board.

SAIF also contends that claimant failed to prove that his condition worsened "sometime after [claim closure] December 24, 1991." After reviewing the record, our prior order and SAIF's argument on reconsideration, we continue to conclude that claimant's condition worsened. Whereas claimant was released to perform light duty work in September 1991, claimant was unable to perform even light duty work from January 6, 1992 until May 5, 1992.

"Waxing and Waning"/Aggravation

Finally, SAIF argues that even if claimant's condition did temporarily worsen after claim closure, claimant failed to prove that the worsening was more than waxing and waning of symptoms contemplated by the award of 25 percent permanent unscheduled disability. As we explained in our prior order, the December 24, 1991 Determination Order, which closed claimant's claim with an award of 2 percent unscheduled permanent disability benefits, constituted "the last arrangement of compensation." See Lindon E. Lewis, 46 Van Natta 237 (1994).

Therefore, although an Order on Reconsideration awarded claimant 5 percent unscheduled permanent disability, and a prior referee awarded claimant 25 percent unscheduled permanent disability, the "base line" for determining whether claimant's compensable condition worsened was the December 24, 1991 Determination Order (finding claimant "medically stationary" in September 1991). Id. at 239.

Upon further consideration, we continue to conclude that claimant's worsened condition resulted in diminished earning capacity in excess of any waxing and waning expected by the Determination Order award of 2 percent. Consequently, claimant carried his burden of proving a compensable aggravation.

Claimant is entitled to an additional attorney fee for services on reconsideration. ORS 656.382(2); Rene G. Gonzalez, 45 Van Natta 499 (1993). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on reconsideration concerning the issue of aggravation is $300 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 response to SAIF's motion), the complexity of the issues, and the value of the interest involved.

Accordingly, on reconsideration, as clarified and supplemented herein, we adhere to and republish our March 24, 1994 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
KENNETH G. BERKLEY, Claimant
WCB Case No. 93-06968
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Neal's order that found that claimant is entitled to chiropractic treatment by a chiropractor other than Dr. Krupa under the terms of a 1988 Stipulation. Claimant cross-requests review, seeking an attorney fee for his counsel's services at the hearings level. On review, the issues are res judicata, construction of a Stipulation, and attorney fees.

We adopt and affirm those portions of the Referee's order which pertained to res judicata and the construction of the Stipulation. We reverse that portion of the order which did not award a carrier-paid attorney fee.

The insurer neither challenged the compensability of claimant's back condition nor the causal relationship between the chiropractic treatment and the compensable condition. Instead, in November 1992, the insurer notified claimant that it "was not authorizing continued [chiropractic] treatment with any doctor other than Dr. Krupa". (Ex. 6A). More than 90 days after receiving this notice, claimant requested a hearing. At the hearing, the insurer contended that it was not responsible for claimant's post-January 1, 1991 chiropractic treatments under the terms of the parties' 1988 Stipulation, while claimant contended that the insurer remains responsible for his continuing chiropractic treatment, even though Dr. Krupa retired as of January 1, 1991.

The Referee found that the issue of treatment with chiropractors other than Dr. Krupa is not precluded because it was not litigated previously. In addition, because this claim arises from different operative facts than prior claims, the Referee found that the claim is not precluded by prior litigation. Finally, the Referee concluded that the terms of the 1988 Stipulation provide for chiropractic treatment for claimant, indefinitely, including treatment by chiropractors other than Dr. Krupa.

By cross-appeal, claimant argues entitlement to a carrier-paid attorney fee award for prevailing at hearing against the insurer's denial of continuing chiropractic treatment. We hold that claimant is entitled to a carrier-paid attorney fee under ORS 656.386(1), based on the following reasoning.

In Gwen A. Jackson, 46 Van Natta 357 (1994), on recon 46 Van Natta 822 (1994), we examined the court's plurality opinion in SAIF v. Allen, supra. Reasoning that neither the "lead" nor concurring opinion were of any precedential value, we reexamined the relevant Supreme Court decisions for further guidance in analyzing the application of ORS 656.386(1). Based on our review of those decisions (Short v. SAIF, 305 Or 541 (1988), and Shoulders v. SAIF, 300 Or 606 (1986), among others), we determined that a claimant was entitled to an attorney fee award under ORS 656.386(1) for finally prevailing against an order or decision denying a medical services claim. We identified the critical inquiry as whether the carrier's conduct constitutes a decision denying the claimant's claim for compensation.

In Jackson, the carrier notified the claimant and her physician that a proposed surgery was excessive, inappropriate and ineffectual treatment. Recommending that the physician withdraw the surgery request, the carrier further advised that if the request was not withdrawn the physician should seek Director review under ORS 656.327. When the claimant requested a hearing, the carrier's position at hearing was that the proposed surgery was neither reasonable nor necessary. The carrier did not dispute that the surgery was causally related to the claimant's compensable condition. Notwithstanding the carrier's notice that it had not and would not issue a denial of the proposed treatment, we reasoned that the carrier's response to the physician's surgery request and its position at hearing constituted a "decision denying the claim for compensation." Inasmuch as we found the surgery to be appropriate, we held that the claimant was entitled to a carrier-paid attorney fee award under ORS 656.386(1) for her counsel's services at hearing and on review.

Here, as in Jackson, the insurer has not contested the causal relationship between claimant's medical services claim and his compensable condition. Nevertheless, again as in Jackson, the insurer has challenged claimant's entitlement to such services. In light of such circumstances, we conclude that the insurer's November 1992 letter stating that it would not authorize claimant's continuing chiropractic treatments, as well as its position at hearing, constitutes a "decision denying the claim for compensation." Since claimant finally prevailed at hearing over that denied medical services claim, we hold that he is entitled to an attorney fee award under ORS 656.386(1) for his counsel's services at the hearing.

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 $800, to be paid by the insurer. Claimant is also entitled to an attorney fee for services on review regarding the insurer's appeal of the chiropractic treatment issue. After considering the factors set forth in the aforementioned rule, we find that a reasonable attorney fee for services on review concerning this issue is $400, to be paid by the insurer. In reaching these conclusions, 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 22, 1993 is reversed in part and affirmed in part. For services at the hearings level regarding the chiropractic treatment issue, claimant is awarded an $800 attorney fee, payable by the insurer. The remainder of the order is affirmed. For services on review concerning the chiropractic treatment issue, claimant's counsel is awarded a $400 attorney fee, payable by the insurer.

In the Matter of the Compensation of
TIMOTHY A. BOSTICK, Claimant
WCB Case No. 93-05050
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Hoguet's order which declined to reclassify claimant's cervical and fractured toe claim from nondisabling to disabling. On review, the issue is claim reclassification. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the claim remained nondisabling on the basis that claimant untimely filed his request for reclassification. We agree that the claim is nondisabling, but for the following reasons.

On May 8, 1991, claimant fractured his left fifth toe and sustained a cervical strain when a scaffold plank fell and hit him on the head and left fifth toe. On May 24, 1991, the insurer accepted the claim for the fractured toe as a nondisabling claim. On August 7, 1992, the insurer accepted the cervical claim as nondisabling. On August 13, 1992, claimant requested reclassification of his claim to disabling by filing a request with the Department.

An October 14, 1992 Determination Order found that the claim should be reclassified as disabling. A November 10, 1992 Order on Reconsideration rescinded the Determination Order, finding that the claim should remain nondisabling.

Claimant had one year from the date of injury in which to seek reclassification of his claim from nondisabling to disabling. ORS 656.262(6)(c). Upon receipt of such a request, the Department shall determine whether the claim is disabling or nondisabling. ORS 656.268(11).

Here, the insurer classified the cervical strain 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 Department lacked authority to address claimant's reclassification request. See Donald R. Dodgin, 45 Van Natta 1642 (1993). As a result, the Determination Order and the Order on Reconsideration were improperly issued and were, therefore, invalid. Nevertheless, the invalidity of the reconsideration order does not remove the issue from the the Hearings Division and the Board. George A. McClellan, 45 Van Natta 2194 (1993) (citing Pacheco-Gonzalez v. SAIF, 123 Or App 312, 315 (1993)).

Where, as here, claimant is precluded, through no fault of his own, from seeking reclassification by the Department because the claim was classified as nondisabling more than one year after the date of injury, claimant may request a hearing on the matter pursuant to ORS 656.283(1). Donald R. Dodgin, supra.[1] On April 26, 1993, claimant requested a hearing on the November 10, 1992 Order on Reconsideration, which classified the claim as a nondisabling injury. Thus, the classification issue was properly before the Referee.

Because the Referee found that the Hearings Division lacked jurisdiction over claimant's reclassification request, the Referee declined to reach the merits. Claimant was not present at hearing, but appeared through his attorney. No witnesses testified at hearing. The parties relied on the exhibits submitted at hearing. Our review is based on the record developed by the Referee. Because we find that the record has been sufficiently developed for our review, see ORS 656.295(5), we proceed to the merits of the reclassification request.

ORS 656.210 provides:

> "No disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period."

Claimant was injured on a Wednesday, May 8, 1991, at approximately one-half hour before his shift ended. (Ex. 5). (May 8th is considered the first day of the three day waiting period. ORS 656.210(3); OAR 436-60-020(2)(b)). Claimant sought treatment at the emergency room that day. The emergency room doctor released claimant to return to regular work on May 15, 1991. (Exs. 2, 3).

Claimant began treating with Dr. Eubanks on Friday, May 10, 1991, who released claimant for modified work on Monday, May 13th. (Ex. 6). Saturday and Sundays are claimant's regularly scheduled days off. However, the record is void as to whether or not claimant returned to modified work on May 13, 1991, and if so, at a reduced wage.[2] The evidence also does not indicate whether or not claimant continued to miss work for a period of 14 days.

Thus, the record supports a finding that claimant was off work for three days, but he has failed to establish that his disability continued for a period of 14 days. Claimant is, therefore, not entitled to temporary disability compensation. See ORS 656.210(3); OAR 436-60-020(2)(b); Tennant v. Lyman Slack Chevrolet, 102 Or App 470 (1990).

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[1] We also stated in Dodgin that a claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling. Because the insurer, in this case, did not accept the cervical claim until August 7, 1992, claimant could not have sought reclassification within the one year time limit.

[2] OAR 436-30-045(5) provides that a claim is disabling if: (a) temporary disability is due and payable; *** (d) the worker is released to and doing a modified job at reduced wages from the job at injury; or (e) if the modified job the worker is released to and doing at the wage of job at injury no longer exists or a job offer is withdrawn.

Based on this record, claimant has failed to establish that he was unable to work or has lost wages due to his compensable injury. Claimant has also failed to establish that he sustained any permanent impairment due to his injury. Consequently, claimant has failed to prove that his claim is disabling.

ORDER

The Referee's order dated August 6, 1993 is affirmed.

May 17, 1994 Cite as 46 Van Natta 944 (1994)

In the Matter of the Compensation of
SANDRA L. BRECHTEL, Claimant
WCB Case No. 92-11729
ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
VavRosky, et al., Defense Attorneys

On April 19, 1994, we dismissed the self-insured employer's request for review of Referee Barber's order that set aside its denial of claimant's aggravation claim for a right elbow condition. This action was taken in accordance with our approval of the parties' "Disputed Claim Settlement," which resolved this dispute, as well as those issues which were pending before the Hearings Division in WCB Case No. 93-12524.

In granting our approval, we acknowledged that the settlement provided that a March 3, 1992 Notice of Closure "is affirmed in all respects" and further stated that the settlement represented the "last arrangement of compensation." Since the Notice of Closure was not an issue, we noted that we were without authority to affirm it. Moreover, since claimant's aggravation claim was not compensable, we further concluded that the settlement could not constitute the last arrangement of compensation.

In response to our order, the parties have submitted a "Stipulation and Agreement" which clarifies their intention regarding the prior settlement. Pursuant to the stipulation, the parties acknowledge that a March 3, 1992 Notice of Closure is the last arrangement of compensation. We treat such a submission as a motion for reconsideration.

Subsequent to our April 19, 1994 order, the parties filed a Claim Disposition Agreement (CDA). On receipt of the CDA, all Board proceedings have been stayed. See OAR 438-09-030(1). Consequently, the parties' stipulation cannot be approved at this time. Nevertheless, in order to retain jurisdiction to consider and approve the stipulation, we withdraw our April 19, 1994 order. Once action has been completed regarding the CDA, we shall proceed with our review of the parties' stipulation.

IT IS SO ORDERED.

In the Matter of the Compensation of
MONICA L. HAMILTON, Claimant
WCB Case No. 93-07366
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Referee Crumme's order that set aside its denial of claimant's back strain injury claim. On review, the issue is compensability.

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

Claimant has a history of preexisting back problems relating to a motor vehicle incident on September 22, 1991. Inasmuch as claimant's back injury at work combined with her preexisting condition, claimant must show that her work injury was the major contributing cause of her resultant back disability and need for treatment. ORS 656.005(7)(a)(B); See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

Referee Crumme found claimant to be credible based upon her demeanor. (O&O at 5). Although not statutorily required, the Board generally defers to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the Referee's credibility finding is based upon observation of claimant's testimony and demeanor, we defer to that determination. International Paper Co. v. McElroy, 101 Or App 61 (1990); Daniel C. Reddekopp, 43 Van Natta 2391, 2392 (1991). Moreover, after reviewing the record, no material discrepancies in the testimony of the witnesses give sufficient cause to overturn the Referee's finding of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Despite our reliance on the Referee's credibility findings, determination of the major contributing cause of claimant's disability and need for treatment is a complex medical question because of claimant's preexisting condition and prior injuries. Therefore, while claimant's testimony is probative, the resolution of this issue turns largely upon an analysis of expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). The medical opinions regarding this case are as follows.

Dr. Breen initially saw claimant on May 27, 1993. He diagnosed a lumbar strain and a cervical strain, "probably" due to claimant's heavy cleaning activities at work six days earlier. (Ex. 3-1).

Claimant was examined the next day by a chiropractor, Dr. Ferrante. As claimant's second attending physician, he noted objective findings of impairment and authorized time loss. (Exs. 4A-2, 6, 8).

Claimant's third treating physician, Dr. Steinhauer, first examined her on June 15, 1993. He noted that symptoms from her neck and knee injuries, sustained in the 1991 motor vehicle accident, were resolved prior to claimant's work incident on May 21, 1993. (Ex. 12-2).

Dr. Steinhauer diagnosed claimant's condition as: "[b]ack strain (lumbar, cervical and thoracic) occurring at work on 5/21/93." (Ex. 12-3). In addition to the unusually strenuous cleaning activities on May 21, Dr. Steinhauer also implicated the amateur manipulation of her supervisor, Mr. Erickson, in the etiology of claimant's back condition: "She is used to baking, not doing a lot of cleaning, and that is how she had her injury. (It did not help matter that her boss gave her an amateur spinal adjustment.)" (Ex. 17).

Dr. Steinhauer referred claimant to Dr. Winslow, D.C., for further evaluation. Dr. Winslow concluded that: "[t]he mechanism of injury sustained on the job on 5-21-93 is the most likely medically probable cause for Ms. Hamilton's current condition." (Ex. 15-3).

The insurer concedes that the language used by Dr. Winslow in his medical opinion identifies claimant's work activities on May 21, 1993 as the major contributing cause of her current disability and need for treatment. (App. Br. at 10). The insurer argues that this opinion is not persuasive because it is conclusory and relates the 1991 motor vehicle accident as "whiplash." (Id. at 11.). We disagree.

Based on his report, we conclude that Dr. Winslow conducted a thorough examination of claimant and issued a well-reasoned report. (Ex. 15). See Somers v. SAIF, 77 Or App 259 (1986). His characterization of claimant's past injury as whiplash does not vitiate his diagnosis. Rather, he clearly favors the current work episode over all other reasons as the cause of claimant's current back problems.

To be sufficient to establish the compensability of a claim, medical experts need not use "magic words" to satisfy the "major contributing cause" test. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986); Donald H. Smith, 44 Van Natta 737, 739 (1992). Rather, in order for a medical opinion to establish the major contributing cause of any condition, the language of those objective medical findings must relate to an activity or exposure or combination of activities or exposure which contributes more to the onset of worsening of a condition than all other conditions, explanations, or exposure combined. McClendon, supra.; See McGarrah v. SAIF, 296 Or 145, 146 (1983).

The testimony of claimant's third treating physician, Dr. Steinhauer, is also well-reasoned and based on complete information. Somers v. SAIF, supra. We, therefore, find him to be persuasive. See Taylor v. SAIF, 75 Or App 583 (1985). While Dr. Steinhauer does not use the "magic words" (i.e., major contributing cause), he does state that (1) claimant's previous neck and knee symptoms had resolved, and (2) the unusually strenuous cleaning activities of May 21, 1993, were the direct cause of her subsequent back strain.

Inasmuch as there is no persuasive medical evidence to the contrary, we find Dr. Steinhauer's explanation (as supported by Dr. Winslow's observations) regarding the etiology of claimant's back condition to be persuasive. Thus, based on claimant's credible testimony and Dr. Steinhauer's opinion, we conclude that claimant's work injury was the major contributing cause of her resultant back disability and need for medical treatment. See ORS 656.005(7)(a)(B).

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

ORDER

The Referee's order dated October 20, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

May 17, 1994 Cite as 46 Van Natta 946 (1994)

In the Matter of the Compensation of
JOHN R. JOHANSON, Claimant
WCB Case No. 93-10812
ORDER OF DISMISSAL
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

The self-insured employer has requested review of Referee Baker's March 18, 1994 Opinion and Order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that the request is untimely, the request for review is dismissed.

FINDINGS OF FACT

The Referee's order issued March 18, 1994. The 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 May 3, 1994, the Board received a copy of the employer's request for review. That copy was provided by the Medical Review Unit of the Department of Consumer and Business Services (DCBS),

Workers' Compensation Division. DCBS's date stamp indicates that it received a copy of the employer's request on April 4, 1994. The copy of the employer's request includes a certificate of mailing attesting that the original request was mailed to the Board on April 1, 1994. The Board has no record of receiving the employer's request for review before May 3, 1994.

CONCLUSIONS OF LAW

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

Filing means the physical delivery of a thing to any permanently staffed office of the Board or the date of mailing. OAR 438-05-046(1)(a). If filing of a request for Board review of a referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id. In the past, such proof has taken the form of an affidavit attesting to the fact that a request was mailed to the Board on a certain date. Greg Carpenter, 40 Van Natta 100, 349 (1988).

Here, the 30th day after the Referee's March 18, 1994 order was April 17, 1994, a Sunday. Therefore, the final day to perfect a timely appeal was Monday, April 18, 1994. See Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as the employer's request for review was not mailed by certified mail, we proceed to determine when the request was actually received by the Board. OAR 438-05-046(1), (a), (b).

The employer's request for Board review was received by DCBS on April 4, 1994, within 30 days of the Referee's order. However, the request was not received by the Board until May 3, 1994, when DCBS submitted a copy of the request to the Board. See Charles A. Lamere, 45 Van Natta 2214 (1993) (Filing of hearing request concerning a noncomplying employer order on Board does not constitute timely filing on Department as required by ORS 656.740(1)). Since DCBS is not a "permanently staffed office of the Board," the Board's first receipt of the employer's request for review of the Referee's March 18, 1994 order did not occur until May 3, 1994. OAR 438-05-046(1)(a). Inasmuch as May 3, 1994 is more than 30 days from the Referee's March 18, 1994 order, the request must be dismissed as untimely filed.[1]

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] We recognize that the employer's request was accompanied by a certificate of mailing stating that the original request was mailed to the Board on April 1, 1994. Yet, in the absence of a receipt establishing that the request was mailed by certified mail, such a certificate is insufficient to overcome the rebuttable presumption that the mailing was untimely when a request is received by the Board untimely. See OAR 438-05-046(1)(b). As noted in Carpenter, that presumption can be overcome. Thus, in the event that the employer can establish that its request for review was timely mailed to the Board, we would be willing to reconsider this decision. Nevertheless, since our authority to reconsider expires within 30 days of this order, the employer must present its submission in an expeditious manner.

In the Matter of the Compensation of
JOHN L. LAW, Claimant
WCB Case Nos. 91-00219 & 90-20445
ORDER ON REMAND
Aller & Morrison, Claimant Attorneys
Gail Gage (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to its April 19, 1994 order, the court has reversed our prior order, which found Cigna Insurance Companies responsible for claimant's low back condition. John L. Law, 44 Van Natta 1091, on recon 44 Van Natta 1619 (1992). Citing SAIF v. Drews, 318 Or 1 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Finding that the July 12, 1990 work activity with Cigna's insured was a material contributing cause of claimant's back condition, the Referee concluded that claimant sustained a "new compensable injury" for which Cigna was responsible. Relying on our order in Ricardo Vasquez, 43 Van Natta 1678 (1991), the Referee only required SAIF, the original insurer, to prove that the subsequent work incident at Cigna's insured was a "material contributing cause" of claimant's disability and need for treatment. On that basis, the Referee concluded that Cigna was responsible for claimant's low back condition. Cigna requested Board review.

On review, we affirmed the Referee's order which held that SAIF had carried its burden of shifting responsibility to Cigna by proving that claimant sustained a "new compensable injury" while working for Cigna's insured. Cigna petitioned for judicial review.

The Court of Appeals reversed our opinion, relying on the Supreme Court's Opinion in SAIF v. Drews, 318 Or 1 (1993). In Drews, the Court held that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1).

Interpreting ORS 656.005(7)(a), the Court reached the following conclusions. "Compensable injury" encompasses an application of the limitation criteria found in ORS 656.005(7)(a)(B). In other words, if the accidental injury described in paragraph (a) combines with a preexisting condition, to be compensable, the injury must be "the major contributing cause of the disability or need for treatment" under subparagraph (B). The Court reasoned that such a determination is made regardless of whether the preexisting condition was compensable.

Turning to ORS 656.308(1), the Court concluded that if the accidental injury was found not to be "the major contributing cause" under ORS 656.005(7)(a)(B), claimant would not have sustained a "new compensable injury involving the same condition" as described in ORS 656.308(1). Consequently, the Court determined that the first employer would remain responsible. Conversely, if the accidental injury was the "major contributing cause," the Court held that responsibility would shift to the subsequent employer because claimant would have sustained a "new compensable injury involving the same condition." SAIF v. Drews, supra.

Thus, on remand, to establish a "new compensable injury" under ORS 656.308, SAIF must prove that the July 12, 1990 incident with Cigna's insured was the "major contributing cause" of claimant's disability and need for medical treatment.

Several doctors examined claimant following the July 12, 1990 work incident with Cigna's insured. Dr. Teller, claimant's initial treating doctor, testified that the incident of July 12, 1990 was the reason that claimant sought treatment the next day. However, Dr. Teller further stated that claimant had experienced a recurrence of symptoms and a recurrence of problems, "which date back to 1985, of which this is very similar." Dr. Teller testified that he would have difficulty saying that the July incident was the major cause of claimant's need for treatment.

Dr. Struckman, an orthopedist who saw claimant on referral from Dr. Teller, opined that claimant's symptoms were primarily caused by his injury of 1985. Dr. Struckman reported that claimant's activities at the subsequent employer (Cigna's insured) were "not a major cause, but rather a temporary exacerbation of a preexisting condition." Dr. Struckman based his opinion on the fact that claimant continued to have symptoms the entire time and had recurring episodes of pain over a long course of time.

Dr. Thomas, a second orthopedist, also saw claimant on referral from Dr. Teller. Dr. Thomas testified that, because claimant had not experienced pain for a while, the July 12, 1990 incident was a new injury.

Finally, claimant was also examined by a panel of physicians at Western Medical Consultants. The Consultants examined claimant on one occasion and reported that claimant's work activity on July 12, 1990 caused claimant's symptoms at that time and was the major cause of his need for treatment.

After reviewing the medical evidence, we find no persuasive reason not to defer to the opinion of Dr. Teller, claimant's initial treating doctor. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Teller's opinion is consistent with claimant's testimony that he continued to experience intermittent, although not severe, back pain following the 1985 injury. Dr. Teller's opinion is also supported by the opinion of Dr. Struckman, who believed that the 1990 incident exacerbated claimant's symptoms, but was not the major cause of his current disability.

Accordingly, based on Dr. Teller's persuasive opinion (as supported by Dr. Struckman's observations), we are not persuaded that the 1990 incident with Cigna's insured was the major contributing cause of claimant's resultant low back disability or need for medical treatment. Therefore, SAIF has failed to carry its burden of proving that claimant suffered a "new compensable injury." ORS 656.308(1); ORS 656.005(7)(a)(B); SAIF v. Drews, supra. Consequently, we hold that SAIF, as the carrier with whom claimant has an accepted back condition, remains responsible for future compensable medical services and disability relating to the condition. Id.

We next reconsider claimant's attorney fee award.

The Referee assessed Cigna a $2,500 attorney fee for claimant's counsel's services at hearing. On review, we initially modified the attorney fee award and assessed SAIF a fee of $1,500, based on claimant's pre-hearing concession regarding compensability. John L. Law, 44 Van Natta 1091 (1992).

On reconsideration, however, we withdrew the $1,500 carrier-paid attorney fee award. Based on the court's decision in Multnomah County School District v. Tigner, 113 Or App 405 (1992), we concluded that, because a hearing before a referee had been held, no fee pursuant to ORS 656.386(1) could be awarded. John L. Law, 44 Van Natta 1619 (1992).

We have since disavowed that portion of our order in Law which held that no fee was awardable under such circumstances. In Penny L. Hamrick, 46 Van Natta 14 (1994), we held that a claimant's counsel is entitled to a carrier-paid attorney fee under ORS 656.386(1) when a carrier rescinds the compensability portion of its denial prior to a hearing regarding responsibility for the claim. Accordingly, based upon the rationale expressed in Hamrick, supra, we conclude that a carrier-paid attorney fee, to be paid by SAIF, is appropriate.

Claimant is entitled to a carrier-paid attorney fee for his counsel's efforts in obtaining compensation for claimant without a hearing; i.e., the withdrawal of the compensability portion of SAIF's denial prior to hearing. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,500 is a reasonable assessed fee for claimant's counsel's pre-hearing services concerning the compensability issue, to be paid by SAIF. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the record), the complexity of the issue presented, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on remand, the Referee's order dated October 9, 1991 is reversed in part and modified in part. That portion of the Referee's order which found Cigna responsible for claimant's low back condition is reversed. The SAIF Corporation's denial is set aside and claimant's claim is remanded

to SAIF for processing according to law. The Cigna Insurance Companies' denial is reinstated and upheld. The Referee's attorney fee award is modified. In lieu of the Referee's award, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
JANIE A. LENGELE, Claimant
WCB Case No. 92-06174
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of that portion of Referee Herman's order that awarded claimant temporary disability benefits from July 15, 1991 to July 13, 1992. In her brief, claimant requests that the Board assess additional penalties for the employer's unreasonable claims processing. On review, the issues are temporary disability benefits and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for her "Ultimate Findings of Fact," as supplemented.

Claimant quit work on July 14, 1991, due to increasing finger pain and disagreement with the employer's personnel policies. Approximately one week after quitting, claimant sought other work. Claimant continued her work search efforts up to the date of the first surgery in November 1991.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

At the beginning of the hearing, the employer accepted a July 15, 1991 "dry" aggravation. Finding that claimant had left work due to her compensable injury and was a member of the work force as of July 15, 1991, the Referee awarded claimant temporary disability benefits from July 15, 1991 to July 13, 1992.

On review, the employer argues that claimant is not entitled to temporary disability because she left work for reasons unrelated to her disability and was, therefore, not in the work force at the time of the aggravation. Claimant responds that she left work in part because of her increasing pain, and remained in the work force. Alternately, claimant argues, she reentered the work force and continued to seek work until her first surgery, such that she is at least entitled to temporary disability from November 1991 until she was released to return to work in July 1992.

To receive temporary disability upon the aggravation of a work-related injury, a claimant must be in the work force at the time of the aggravation. Cutright v. Weyerhaueser, 299 Or 290 (1985). The critical time for determining whether claimant has withdrawn from the work force is at the time of her disability. Weyerhaueser Co. v. Kepford, 100 Or App 410, 414 (1990). However, withdrawal from the work force is not irrevocable. Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990). Claimant can reenter the work force for aggravation purposes if, although not employed at the time, she is willing to work and is making reasonable efforts to obtain employment; or is willing to work, although not employed at the time of disability and not making reasonable efforts to obtain employment because of her work-related injury/condition, where such work-finding efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989); Lyle L. Smith, 43 Van Natta 169 (1991). We modify the Referee's order to award claimant temporary disability benefits from November 11, 1991 to July 13, 1992.

Here, claimant compensably injured her right index and middle fingers on January 31, 1991. Although Dr. Claridge, claimant's attending physician, noted a neuroma of the index finger that might require surgery in the future, he declared her medically stationary and released her to return to regular work on March 6, 1991. Thereafter, claimant returned to work for the employer. Claimant left work on July 14, 1991, in part because her finger was bothering her, and in part over disagreement with the employer's personnel policies.

Claimant was examined on July 15, 1991 by Dr. Claridge. The doctor noted that claimant's right index finger was hypersensitive and referred her to Dr. Karmy for possible surgery. Dr. Claridge did not opine that claimant was unable to work at that time. On July 16, 1991, claimant filed a claim for unemployment compensation. She indicated that she quit work because she had to do other employes' work and management would not correct the problem. Approximately one week after quitting, claimant sought other work. Claimant continued her work search efforts up to the date of surgery in November 1991.

Claimant was examined by Drs. Logan and Watson on October 3, 1991. They opined that claimant was not medically stationary and agreed that she would require surgery in the near future. Dr. Karmy performed surgery on November 11, 1991. Subsequently, Dr. Nathan performed additional surgeries on May 12, 1992 and June 23, 1992. Claimant was again declared medically stationary and released to return to work on July 13, 1992.

The record does not support claimant's contention that she quit work on July 14, 1991 due to her compensable injury. Nonetheless, we find claimant's unrebutted testimony that she actively sought work from late July 1991 through the date of surgery in November 1991 persuasive. Under such circumstances, we conclude that claimant reentered the work force, that she was willing to work, and that she made reasonable efforts to obtain employment prior to November 11, 1991, at which time she was no longer able to work due to her compensable finger injury. Consequently, we find that claimant is entitled to temporary disability benefits from November 11, 1991 to July 13, 1992. Dawkins, supra.

Penalties

The Referee assessed penalties based on the employer's untimely and unreasonable claims processing. The employer concedes that its claims processing was untimely. On review, claimant alleges that future awards of permanent disability benefits have been delayed by the employer's processing of her aggravation claim. Therefore, she contends, she should be awarded additional penalties based upon any future awards of permanent disability which have been delayed by the employer's unreasonable conduct.

Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). If claimant believes that the employer's processing of her aggravation claim warrants additional penalties related to future awards of permanent disability, claimant should commence a new proceeding raising this as an issue at such time as any future award of permanent disability is made and a penalty can be calculated. We decline to consider her request at this time.

Inasmuch as claimant's compensation has been reduced, no attorney fee is awarded for claimant's counsel's services on Board review. ORS 656.382(2).

ORDER

The Referee's order dated February 23, 1993 is modified in part and affirmed in part. In lieu of the Referee's award of temporary disability benefits from July 15, 1991 to July 13, 1992, claimant is awarded temporary disability benefits from November 11, 1991 to July 13, 1992. The out-of-compensation attorney fee awarded to claimant's counsel by the Referee's order is modified to award a fee in an amount equal to 25 percent of the compensation awarded by this order, not to exceed $1,050. The penalty assessment is modified to assess a penalty in an amount equal to 25 percent of the temporary disability benefits accruing from November 11, 1991 to July 13, 1992, to be equally divided between claimant and her attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
REYNA MEJIA, Claimant
WCB Case Nos. 92-07430 & 92-06434
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Thye's order that: (1) upheld the SAIF Corporation's denial of claimant's right neck and right shoulder claim; and (2) declined to assess penalties and related attorney fees for SAIF's and Safeco Insurance Companies' (Safeco's) denials of the same condition. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions regarding compensability with the following modification and supplementation.

For most of the past decade, claimant has worked for the employer's nursery as a general laborer. In 1986, while Safeco was on the risk, claimant sustained a compensable injury that was diagnosed as cervical and lumbosacral strain/sprain. Safeco originally denied the claim, but after hearing and Board review, accepted claimant's low back, upper back and neck condition. The claim was closed without an award of permanent disability.

On November 22, 1989, claimant was involved in a non-work related motor vehicle accident in which she sustained neck, left shoulder, left hip, left knee and chest soft tissue injuries. Shortly thereafter, claimant began treating with Dr. Conrad, who apparently is a family physician.

SAIF came on the risk sometime before April 7, 1992, the day on which claimant stated that she injured her right shoulder and right neck at work while turning her head to the left. Claimant treated with Dr. Conrad for that injury. She was eventually examined by several physicians on SAIF's behalf.

Claimant alleged at hearing that she had sustained a new industrial injury on April 7, 1992. To prevail on this theory, claimant must establish that her work activities were a material contributing cause of her disability or the need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). On review, SAIF argues that this case should be analyzed as a resultant condition under ORS 656.005(7)(a)(b), in which case the major contributing cause standard would apply. We need not resolve that issue because we conclude that, even under the lower standard, claimant has failed to meet her burden of proof.

Claimant relies on the reports of her treating physician, Dr. Conrad. In an April 21, 1992 chart note, Dr. Conrad opined that claimant's current neck and arm pain was the result of the industrial injury. (Ex. 31-14). Dr. Conrad's opinion was based, in part, on an April 10, 1992 MRI that showed mild disc bulging in the lower cervical region without nerve compression. (Ex. 50).

On June 21, 1992, Dr. Conrad concluded that claimant's neck pain was the result of her 1989 motor vehicle accident. (Id. at 15). Dr. Conrad's July 28, 1992 and December 1, 1992 chart notes reflect his belief that claimant's neck and right arm pain was exacerbated by her April 1992 injury. (Id. at 16, 17).

On June 10, 1992, Dr. Peterson, neurologist, and Dr. Fuller, orthopedic surgeon, examined claimant on SAIF's behalf. They concluded that claimant had subjective nonverifiable pain, right neck and shoulder, associated with mild thoracic outlet syndrome. (Ex. 56-4). In reaching that conclusion, they determined that, apart from "some very minimal changes in the midcervical discs", claimant's MRI was normal. They concluded that, at most, claimant's April 7, 1992 work incident had caused a symptomatic flare-up. (Id. at 3, 6).

On August 4, 1992, claimant was examined by Dr. Rosenbaum, neurosurgeon. Dr. Rosenbaum diagnosed cervical strain symptomology, (Ex. 61-2), and concluded that claimant's MRI revealed very minor degenerative changes and no root compression or intraspinal impingement. (Id.)

Thereafter, Dr. Conrad issued a report in which he declined to concur with the report of Drs. Peterson and Fuller. (Ex. 62). Instead, he focused on the change in claimant's symptoms following the April 7, 1992 incident, and concluded that claimant's current condition was related, in major part, to the injury she sustained that day. (Id. at 2; Ex. 63-2). He also stated, "Although an IME in June 1992 does not consider her cervical MRI findings significant, I feel that they are consistent with an industrial injury causing right arm pain and inability to lift objects." (Ex. 63-1).

In February 1993, Dr. Brown, neurologist, and, Dr. Fuller, orthopedic surgeon, examined claimant, again on SAIF's behalf. (Ex. 64). Drs. Brown and Fuller diagnosed "[s]ubjective nonverifiable pain in the neck, shoulders, arms, thoracic spine and, occasionally, the lumbar spine, present in a verifiable degree since 1986." (Id. at 4). They disagreed with Dr. Conrad's conclusion that claimant's MRI was pathologically abnormal, and found no causal relationship between claimant's current condition and the April 1992 incident. (Id. at 5).[1]

When the medical evidence is divided, we tend to give greater weight to the reports of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We find persuasive reasons to give minimal weight to the reports of Dr. Conrad, claimant's treating physician.

First, Dr. Conrad changed his opinion regarding the cause of claimant's current condition several times during his treatment of claimant: He first opined that claimant's current condition was the result of the industrial injury. Then, he opined that claimant's current condition was the result of her non-compensable 1989 motor vehicle accident, or was exacerbated by the April 1992 injury. Finally, Dr. Conrad concluded that claimant's current condition was caused, in major part, by her April 1992 injury.

At no point did Dr. Conrad offer any explanation for his differing opinions regarding the cause of claimant's current condition. For that reason alone, we attach minimal probative weight to any of his reports. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or App 630 (1987).

Second, Dr. Conrad's opinions rest, in large part, on his unpersuasive interpretation of claimant's MRI results. Dr. Conrad felt that those results were consistent with an industrial injury. In contrast, all of the examining physicians, each of whom is a neurologist or an orthopedic surgeon, concluded that claimant's MRI was not pathologically abnormal.

Because the evaluation of claimant's MRI results involves expert analysis of objective evidence, rather than external observation of claimant, we do not give special deference to Dr. Conrad's opinion as opposed to the opinions of the examining physicians. See Allie v. SAIF, 79 Or App 284 (1986). Furthermore, we conclude that Dr. Conrad's conclusions regarding claimant's MRI results are not sufficient to overcome the well-founded opinions of the examining physician-specialists. Because Dr. Conrad relied so heavily on claimant's MRI results, and because he changed his opinion regarding causation without explanation, we do not extend the treating physician preference to his opinions.

Because we have found persuasive reasons not to defer to Dr. Conrad's opinions, we conclude that claimant has failed to establish the compensability of her current condition.

Penalties and Attorney Fees

We adopt the Referee's conclusions regarding penalties and attorney fees.

ORDER

The Referee's order dated June 16, 1993 is affirmed.

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[1] Claimant takes exception to Drs. Fuller's and Brown's conclusion that objective findings do not include pain on palpation. Claimant's argument is well-taken. See Todd N. Hellman, 44 Van Natta 1082 (1992); see also ORS 656.005(19).

In the Matter of the Compensation of
SAMUEL D. MURASKI, Claimant
WCB Case No. 93-00898
ORDER ON REVIEW
Stunz, Fonda, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband, Neidig, and Hall.

The insurer requests review of Referee Peterson's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant developed bilateral carpal tunnel syndrome while employed in Idaho in 1985. He made a complete recovery without residuals after undergoing bilateral wrist surgery. It is not clear from the record whether this was a compensable claim under Idaho law.

In any event, claimant was asymptomatic for approximately 7 years until he experienced a gradual onset of bilateral hand numbness in June 1992 while employed as a long-haul truck driver in Oregon. By December 1992, claimant's hands were going completely numb while holding the steering wheel as he drove his employer's truck. Claimant came under the care of an orthopedic surgeon, Dr. Botimer, who diagnosed recurrent carpal tunnel syndrome aggravated by claimant's driving. The insurer denied the compensability of claimant's carpal tunnel syndrome on January 11, 1993.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the insurer's denial, finding that truck driving was the major contributing cause of a worsening of claimant's hand condition. In so doing, the Referee found persuasive Dr. Botimer's opinion that claimant's driving aggravated his carpal tunnel syndrome. In addition, the Referee also relied on claimant's former treating physician, Dr. Dahlin, who indicated in a concurrence letter drafted by claimant's counsel that claimant's employment was the major contributing cause of a worsening of his bilateral carpal tunnel syndrome.

On review, the insurer contends that claimant's carpal tunnel syndrome is not compensable because the medical evidence does not establish a pathological worsening of the preexisting condition. Specifically, it asserts that the Referee erred in not relying on the medical opinion of an examining neurologist, Dr. Wilson. Dr. Wilson concluded, after comparing nerve conduction studies done in 1985 and 1992, that there was no worsening of claimant's underlying carpal tunnel pathology and that claimant's current symptoms were primarily due to flexor tendinitis.

Despite claimant's 7-year period without symptoms, the medical opinions of Drs. Botimer and Dahlin imply that claimant still had a preexisting bilateral carpal tunnel syndrome prior to commencing work for the insured in the fall of 1991. We so find. In order to establish an occupational disease claim for bilateral carpal tunnel syndrome, claimant must prove by a preponderance of the evidence that his work activities were the major contributing cause of a pathological worsening of the preexisting carpal tunnel syndrome condition. See ORS 656.802(2); Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979). Claimant has not sustained his burden of proof.

As the Referee noted, Dr. Wilson attributes claimant's current bilateral hand symptomatology primarily to flexor tendonitis. (Ex. 32).[1] However, Dr. Wilson bases his opinion that claimant's carpal

[1] On review, both parties frame the issue as the compensability of claimant's bilateral carpal tunnel syndrome. We also note that the insurer's denial was of carpal tunnel as opposed to tendinitis. We, therefore, decide the issue of the compensability of the diagnosed carpal tunnel syndrome and do not consider whether claimant's diagnosed tendinitis is related to his employment.

tunnel condition has not worsened entirely on a comparison of nerve conduction studies performed in 1985 and 1993. (Exs. 31, 32). We do not find such a comparison persuasive because the studies performed in 1985 were taken when claimant had not yet recovered from his carpal tunnel syndrome. Accordingly, we accord Dr. Wilson's conclusions little weight.

Moreover, claimant's bilateral hand condition was asymptomatic for approximately 7 years prior to his seeking care from Dr. Botimer in November 1992 when his hands began to go numb while holding the steering wheel of the employer's truck. Dr. Wilson does not address this history in his causation analysis. Because of this, we further discount his opinion. See Somers v. SAIF, 77 Or App 259 (1986).

Although Dr. Wilson's opinion does not persuasively rebut other medical evidence addressing causation, we still find that claimant has failed to sustain his burden of proof.

Dr. Botimer, claimant's attending physician, stated that claimant's truck driving employment aggravated his carpal tunnel syndrome. (Ex. 23). We tend to give greater weight to a claimant's treating physician's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, however, we find a persuasive reason to discount Dr. Botimer's medical opinion.

Dr. Botimer only opined that claimant's truck driving "aggravated" his carpal tunnel syndrome. Dr. Botimer does not confirm, let alone address, whether claimant's employment worsened the underlying carpal tunnel condition. For this reason, we find Dr. Botimer's opinion insufficient to satisfy claimant's burden of proof.

Dr. Dahlin, claimant's former treating physician, opined that claimant's employment was the major contributing cause of a worsening of his carpal tunnel syndrome. (Ex. 33). However, Dr. Dahlin's opinion, expressed in a check-the-box manner, is entitled to little weight. See David J. Rowley, 45 Van Natta 1659 (1993).

There is no other medical evidence that discusses the causation issue. Absent persuasive evidence of a pathological worsening, we are compelled to conclude that claimant's bilateral carpal tunnel syndrome claim is not compensable. Accordingly, the insurer's January 11, 1993 denial is upheld.

ORDER

The Referee's order dated May 11, 1993 is reversed. The insurer's January 11, 1993 denial is reinstated and upheld.

Board Member Hall dissenting.

The majority concludes that claimant failed to sustain his burden of proving that his occupational disease claim for bilateral carpal tunnel syndrome is compensable. Like the Referee, I am convinced that claimant did prove a compensable worsening of his carpal tunnel syndrome condition and, thus, dissent.

The majority discounts the medical opinion of the treating physician, Dr. Botimer, because it finds that his opinion does not confirm a "worsening" of claimant's underlying carpal tunnel condition. In doing so, the majority draws a distinction between "aggravation" and a "worsening" that does not exist. Considering Dr. Botimer's medical opinion in its entirety, I would interpret his use of the word "aggravated" to mean that claimant's underlying carpal tunnel condition had worsened.

The majority also discounts Dr. Dahlin's opinion by describing it as a "check-the box" report. Although Dr. Dahlin did signal his concurrence with a letter drafted by claimant's counsel by checking a box, the explanation for Dr. Dahlin's concurrence is well-stated in the body of the letter. The letter makes it clear that Dr. Dahlin's opinion was based on a thorough review of the relevant medical records, as well as on prior examinations and on careful consideration of the facts of the claim. This was far from a conclusory opinion. The majority does claimant a great disservice by casually discounting the most thorough and well-reasoned opinion in the record.

Unlike the majority, I would find that the medical record as a whole establishes that claimant has sustained his burden of proving that his occupational disease claim is compensable. For this reason, I must respectfully dissent.

In the Matter of the Compensation of
JOHN P. NEWTON, Claimant
WCB Case No. 91-11193
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Hazelett's order that: (1) found that the insurer did not issue a "back-up" denial of a cervical disc condition; (2) upheld the insurer's denial of compensability for a cervical disc condition; and (3) declined to award a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Cervical Strain

In November 1980, claimant fell from a ladder and was treated for lumbar and cervical strains. Claimant asserts that he made a claim for a cervical strain and, because the insurer neither accepted nor denied the claim, it was "de facto" denied. Claimant further contends that the cervical strain is compensably related to the 1980 injury. The Referee upheld the insurer's denial. We disagree with the Referee's conclusion with regard to claimant's cervical strain.

A physician's report requesting medical services for a specified condition constitutes a "claim." Safeway Stores, Inc. v. Smith, 117 Or App 219, 227 (1993). We agree with claimant that, because there were physicians' reports following the fall that diagnosed a cervical strain and prescribed treatment for such condition, (Exs. 11, 12), there was a claim for a cervical strain.

The insurer maintains that the cervical strain "was clearly encompassed in the 1980 claim." We understand the insurer to argue that it previously accepted the cervical strain. Whether an acceptance occurs is an issue of fact. E.g. SAIF v. Tull, 113 Or App 449, 454 (1992). The 801 form indicated that a "back injury" was accepted. (Ex. 1). Two subsequent partial denials also referred to the insurer's acceptance of low back and right shoulder injuries. (Exs. 75-1, 131-1). Based on this evidence, we find that acceptance was limited to a back injury and right shoulder injury and did not include the cervical strain.

Furthermore, the medical evidence shows that the cervical strain was caused by claimant's fall from the ladder. (Exs. 11, 12, 19, 22). Therefore, claimant proved compensability. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over the Referee's order that upheld the insurer's denial insofar as it pertained to the cervical strain. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the cervical strain is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and those portions of claimant's appellant's and reply briefs devoted to this issue), the complexity of the issue, and the value of the interest involved (with a view that all compensation for the cervical strain has been paid).

Finally, claimant contends that he is entitled to a penalty and related attorney fee because the insurer issued a "de facto" denial of the cervical strain and such denial was unreasonable. In order to be entitled to a penalty and related attorney fee under ORS 656.262(10) and 656.382(1), there must be "amounts then due" upon which to base a penalty or a resistance to the payment of compensation for an attorney fee award. See Wacker Siltronic Corp. v. Satcher, 91 Or App 654, 658 (1988); SAIF v. Condon, 119 Or App 194 (1993). Here, there is no evidence that the insurer failed to pay any compensation with regard to the cervical strain. Therefore, claimant is not entitled to a penalty or attorney fee.

Cervical Disc Condition

Following the 1980 fall, claimant developed right shoulder symptoms and underwent three surgeries. In August 1983, claimant slipped and fell on his right shoulder. In 1986, claimant fell down a stairway. In 1987, he was in a motor vehicle accident and was treated for neck pain.

In February 1991, claimant had respiratory symptoms and, after a period of coughing, experienced right neck pain. A cervical myelogram showed small lateral root filling defects at C4-5 on the right and bilaterally at C5-6. Claimant asserts that his cervical disc condition is a consequence of his 1980 fall and that he proved that the fall is the major contributing cause of his need for treatment and disability. See ORS 656.005(7)(a)(A).

Dr. Bernstein, neurosurgeon, examined claimant in February 1991. He diagnosed a "cervical disc", stating that the "developmental pathology of this condition could have been related to the initial trauma in or about 1980 with a subsequent development of spondylotic change and consequently abnormal disc pathology on a temporal basis." (Ex. 132A-1). Dr. Bernstein further reported that, "[w]ithout any intervening trauma, one would find it medically reasonable to consider that his industrial injury is the major contributing cause of his present cervical condition." (Id.)

After claimant's attorney provided Dr. Bernstein with medical records relating to claimant's 1987 motor vehicle accident, he stated that claimant's 1980 cervical injury "involved predominantly the right side" and that his neck pain in 1987 was more on the left. (Ex. 133). Dr. Bernstein therefore found that the 1987 accident "did not significantly change the course of [claimant's] original cervical spine injury of 1980" and that his opinion regarding causation was unchanged. (Id.)

Dr. Kaplan, neurologist, examined claimant once in August 1992. He diagnosed "cervical radiculopathy on the right at C4-5 and C5-6 bilaterally." (Ex. 136-3). According to Dr. Kaplan, the 1980 injury likely caused loosening of a ligament or altered the anatomy of the cervical spine, which, in combination with the coughing spell, caused a herniated disc. (Exs. 136-3, 138-8, 138-9, 138-13). Dr. Kaplan, however, could not state whether the 1980 injury or the coughing episode was the major contributing cause of claimant's condition. (Ex. 138-20, 138-21).

At the insurer's request, Dr. Herndon, neurologist, provided an opinion based on a review of the medical records. Dr. Herndon found that the 1987 motor vehicle accident and coughing spell were the major contributing causes of claimant's condition rather than "the remote [1980] injury which did not appear to cause significant neck symptoms." (Ex. 132B).

Dr. Butler, physiatrist, treated claimant in 1981 for his lumbar and cervical symptoms and also reviewed the medical record at the insurer's request. He reported that, at the time of claimant's treatment in 1981, there was no evidence of a cervical disc condition and that claimant's treatment at that time was for a soft tissue injury. (Ex. 134-1). Dr. Butler also found that the 1987 motor vehicle accident, the two falls and the sneezing episode all "could have caused a cervical disc problem" and that he felt that the sneezing spell caused the cervical condition. (Id.)

We first note that none of the physicians indicated that claimant sustained a cervical disc injury from his 1980 fall. Instead, the physicians supporting compensability found that the 1980 injury caused changes to the cervical area that resulted in a cervical disc condition. Therefore, we agree with claimant that ORS 656.005(7)(a)(A) is the applicable statute for determining compensability and, in order to carry his burden of proof, claimant must show that the 1980 injury is the major contributing cause of his need for treatment and disability. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In evaluating the medical evidence, we find that Dr. Kaplan did not offer proof of compensability. As noted above, Dr. Kaplan did not indicate that the 1980 injury was the major contributing cause of claimant's cervical disc condition. Dr. Kaplan's initial report stated only that it was "possible" that the 1980 injury "could have caused" either weakening of a ligament or formation of an osteophyte which greatly enhanced his chance of developing a cervical radiculopathy "due to his severe coughing spell." (Ex. 136-3) (emphasis added).

During his deposition, Dr. Kaplan indicated that it was "probable" that the 1980 injury caused such changes which led to a cervical herniation. (Ex. 138-13). Furthermore, in response to claimant's attorney's question, Dr. Kaplan first agreed that the 1980 fall was the major contributing cause of the cervical disc condition. (Id. at 19-20). However, Dr. Kaplan further explained that it was a "difficult" to say whether the fall was the major contributing cause and that, although claimant probably would not have herniated his disc without the 1980 injury, he likely would not have herniated his disc without experiencing the coughing spell. (Id. at 20-21). We find that such statements are insufficient to show that the 1980 injury was the major contributing cause of claimant's cervical disc condition.

We further find that Dr. Bernstein's opinion is not persuasive. First, Dr. Bernstein in no way explains the effect, if any, on claimant's cervical condition by the coughing episode that directly preceded the onset of severe neck pain. We find such an absence significant in view of the fact that all of the physicians, including Dr. Kaplan, attributed claimant's condition at least in part to the coughing event.

Furthermore, Dr. Bernstein's opinion appears to be premised on a history that claimant's neck symptoms did not abate following the 1980 fall. Although claimant testified that he had never been free of neck pain from the fall, the record does not support such a history. Between February 1982 and August 1986, claimant did not report any neck pain and, in February 1983, denied experiencing neck symptoms. (Exs. 39, 60-2, 109). Moreover, during this period claimant consistently sought treatment for his right shoulder and, thus, had ample opportunity to report any neck symptoms.

Dr. Bernstein also provides very little explanation for his opinion, stating only that the 1980 injury caused a "spondylotic change" and "abnormal disc pathology." Finally, his opinion is contradicted by Drs. Herndon and Butler. For these reasons, we find Dr. Bernstein's opinion to be unpersuasive. See Weiland v. SAIF, 64 Or App 810 (1983).

Having decided not to defer to Dr. Bernstein's opinion and because the remaining opinions, including that of Dr. Kaplan, do not establish that claimant's 1980 injury is the major contributing cause of his cervical disc condition, we conclude that he failed to prove compensability. See ORS 656.005(7)(a)(A).

Claimant's final argument is that the insurer's denial of the cervical disc condition was not timely issued and, therefore, unreasonable. See ORS 656.262(10), 656.382(1). Having found that the claim is not compensable, claimant is not entitled to a penalty or related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599, 605 (1991).

ORDER

The Referee's order dated June 30, 1993 is reversed in part and affirmed in part. The insurer's denial insofar as it pertains to the cervical strain is set aside and the cervical strain claim is remanded to the insurer for processing according to law. For services at hearing and on review regarding the cervical strain, claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DENNIS NIXON, Claimant
Own Motion No. 94-0119M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights expired on July 5, 1982. SAIF recommends that the Board reopen claimant's claim for the payment of temporary disability compensation when the status of the surgical procedure has been clarified. The proposed surgical procedure has not been found to be reasonable and necessary by the MCO.

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 April 21, 1994, CareMark Comp, the MCO, notified Dr. Schachner, claimant's treating physician, that the MCO was unable to approve claimant's proposed left knee arthoscopic exam and possible patellofemoral arthroplasty. Dr. Vessely, examining physician, opined that "[t]he track record for this procedure is very poor and in a young, active person, the chances of this holding up is almost impossible." Dr. Vessely recommended instead that claimant undergo an arthroscopic exam, but if the disease process seemed to be all patella-femoral, "then a Maquet procedure or a tibial tubercle osteoplasty would be more indicated than doing a replacement." Thus, the necessity of claimant's proposed surgery is in dispute, and remains in denied status. Therefore, at this time, the Board is unable to grant claimant's request for reopening, as claimant has not established that the proposed surgery is reasonable and necessary.

Although SAIF recommends that the Board reopen claimant's claim when (that is, if) the surgery has been approved, the Board is unable to take any action at this time because the dispute over the reasonableness of the proposed surgery has not be resolved. Claimant may again submit his request for reopening when the dispute is resolved. Therefore, we are unable to grant SAIF's request to reopen the claim at this time.

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.

May 17, 1994 Cite as 46 Van Natta 959 (1994)

In the Matter of the Compensation of
EARL PRETTYMAN, Claimant
Own Motion No. 94-0175M
OWN MOTION ORDER OF ABATEMENT
Richard Sly, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 6, 1994 Own Motion Order in which we declined to reopen his 1979 industrial claim for the payment of temporary disability benefits as he had not established he was in the work force at the time of disability. With his request for reconsideration, claimant's attorney stated he was not notified timely of SAIF's recommendation, and wishes additional time to submit information regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file evidence with respect to the work force issue within 14 days of the date of this order. SAIF is requested to file a response to the motion within 14 days of the receipt of the above information. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRENDA H. TAYLOR, Claimant
WCB Case No. 93-07691
ORDER ON REVIEW
Parker, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral leg condition. In his brief, claimant requests that the Board remand the case to the Referee for the taking of additional evidence in the form of a chart note. With its brief, SAIF submits additional evidence which it requests the Board include in the remand to the Referee, if claimant's request for remand is granted. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant was examined by Dr. Ushman, her treating physician, on August 5, 1993. Dr. Ushman is a physician with Kaiser Permanente and filled out a Kaiser Permanente form on the day of the August 5, 1993 examination regarding that examination. Dr. Ushman checked a box on that form indicating that claimant's condition was probably the result of industrial exposure or injury. (Ex. 30). This form also stated "DICTATION TO FOLLOW." Id.

SAIF received Dr. Ushman's transcribed August 5, 1993 chart note on September 24, 1993. SAIF mailed a copy of this chart note to claimant's attorney on September 28, 1993, the date of the hearing. On September 30, 1993, claimant's attorney received the transcribed chart note from SAIF and requested that the Referee admit it into evidence.

On October 1, 1993, the Referee issued an order upholding SAIF's June 23, 1993 denial, as amended July 30, 1993. On October 4, 1993, claimant's attorney renewed his request that the record be reopened for the submission of Dr. Ushman's chart note. The Referee declined to reopen the record.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant contends that the Referee erred in denying her request to reopen the record for the admission of an August 5, 1993 chart note from Dr. Ushman, claimant's treating physician. Claimant also contends that, because of the Referee's error in failing to reopen the record for Dr. Ushman's chart note, the record was incompletely or otherwise insufficiently developed. Therefore, claimant argues, the case should be remanded to the Referee for further evidence taking.

We do not address claimant's contention that the Referee erred in denying her request to reopen the record for Dr. Ushman's chart note because, as explained below, even if we considered the August 5, 1993 chart note at issue, the result in this case would not be changed. For the same reason, we deny claimant's request for 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). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

We are not persuaded that the evidence that claimant seeks to have introduced on remand is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra.

Prior to his August 5, 1993 examination, Dr. Ushman repeatedly opined that there was only a "possibility" that claimant's condition was the result of her work activities. (Exs. 2, 3-2, 17, 24, 25). On July 9, 1993, Dr. Ushman referred claimant to Dr. Corrigan, orthopedist, requesting that he provide information regarding whether claimant really had an injury or illness and, if so, whether it was work related. (Ex. 25-2). On July 14, 1993, Dr. Corrigan examined claimant and diagnosed "left gluteal and tensor fascia femoris muscle pain, etiology undetermined." (Ex. 27-3). Dr. Corrigan also stated that he could not make a causal relationship between claimant's complaints and any work activities. (Ex. 27-4).

Following Dr. Corrigan's examination, claimant returned to Dr. Ushman on July 21, 1993, who then diagnosed "[m]uscular pain, etiology undetermined, possible fibromyalgia." (Ex. 28-2). On August 5, 1993, Dr. Ushman examined claimant again and checked the box on the Kaiser form indicating that claimant's condition was probably the result of industrial exposure or injury. (Ex. 30). In the transcribed chart note claimant seeks to have admitted on remand, Dr. Ushman explained that claimant brought in the pedal she uses at work while typing dictation. After examining and experimenting with this pedal, Dr. Ushman stated that he was now listing claimant's condition as "probably work related."

However, Dr. Ushman examined claimant again on August 16, 1993 and indicated that claimant's condition was "possibly" work related. (Ex. 31). Given the fact that Dr. Ushman subsequently reverted to his prior opinions that claimant's condition is only possibly work related, we are not persuaded that Dr. Ushman's August 5, 1993 chart note is reasonably likely to affect the outcome of the case.

For the above reason, we are unpersuaded that the current record is improperly, incompletely, or otherwise insufficiently developed without the proffered evidence from Dr. Ushman. Accordingly, we deny claimant's remand motion. Because we have denied claimant's motion to remand, we do not consider SAIF's request that, if the case is remanded to admit Dr. Ushman's August 5, 1993 chart note, additional chart notes from Dr. Ushman dated September 9, 1993, and October 26, 1993, also be admitted on remand.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following supplementation. Claimant relies on the opinions of Dr. Denker, M.D., and Dr. Ushman to support her argument that her work activities are the major contributing cause of her bilateral leg condition. We do not find these opinions meet claimant's burden of proof.

On June 14, 1993, Dr. Denker examined claimant and checked a box on the Kaiser form indicating that claimant's condition was probably the result of industrial exposure or injury. (Ex. 14). Dr. Denker diagnosed "overuse tendinitis, left hip," and explained that claimant's holding her leg in one position for long periods "sets up a nerve-tendon-muscle syndrome." (Ex. 15).

However, Dr. Denker examined claimant only once. In contrast, Dr. Ushman has treated claimant since she initially sought medical treatment on June 4, 1993. Furthermore, Dr. Ushman subsequently found that claimant's hip function argued against any significant left hip pathology. (Ex. 25-2). In addition, Dr. Ushman's opinions read as a whole indicate only that it is "possible" that claimant's condition is caused by her work activities. (Exs. 2, 3-2, 9, 10-1, 17, 24, 25-2, 28, 31). As discussed above, although Dr. Ushman indicated on August 5, 1993, that the work activities "probably" caused claimant's condition, he subsequently reverted to his prior opinions that work activities "possibly" caused the condition. (Exs. 30, 31). A possibility is insufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

ORDER

The Referee's order dated October 1, 1993 is affirmed.

In the Matter of the Compensation of
BARBARA J. WIKOFF, Claimant
WCB Case No. 93-03683
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Black's order which: (1) affirmed that portion of an Order on Reconsideration that declined to award any additional unscheduled permanent disability for claimant's right shoulder condition; and (2) reversed that portion of an Order on Reconsideration that awarded 41 percent (78.72 degrees) scheduled permanent disability for claimant's right arm condition. On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

We do not adopt the following finding made by the Referee: "Dr. Weinman has not reported measurable impairment of claimant's right upper extremity as due to her compensable condition including the recent surgery." We also do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

By an Order on Reconsideration, claimant was awarded 41 percent scheduled permanent disability for the loss of use or function of her right arm. (Ex. 28). The Referee reversed this award, based on his finding that claimant's treating doctor did not relate the measured right arm impairment to her compensable conditions. We disagree.

By stipulation, the employer accepted claims for upper dorsal strain and rheumatoid arthritis of the right shoulder and arm. (Ex. 12). Claimant received no scheduled permanent disability award for the right arm when her claim was closed in 1990. (See Ex. 10). The claim was reopened and closed again in September 1992. (Ex. 26). Claimant requested reconsideration of the September 1992 Determination Order, which again awarded no additional permanent disability. Upon reconsideration, claimant received an award of scheduled permanent disability for the right arm, based on a physical capacities examination (PCE) approved by Dr. Weinman, the treating physician. (Ex. 28; see also Exs. 20, 22).

After our review of the record, we conclude that the right arm impairment measured in the August 1992 PCE and approved by Dr. Weinman is related to the accepted conditions. The PCE was performed for the purpose of providing claim closing information for claimant's compensable conditions, identified as right shoulder total joint replacement and rheumatoid arthritis. (Ex. 20-1). No other potentially contributory conditions were identified in the examination. Dr. Weinman agreed with the PCE findings, stating that the PCE correctly identified claimant's limitations.[1] Under these circumstances, we find that Dr. Weinman related claimant's right arm impairment to her accepted conditions.

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[1] Dr. Weinman also opined that, following her total shoulder replacement surgery, claimant's shoulder was functionally better than it had been prior to the surgery. Nevertheless, he agreed that claimant's limitations were accurately reflected in the PCE, which showed right arm impairment. We do not consider these opinions to be inconsistent or contradictory, and we give effect to both opinions expressed by Dr. Weinman.

We further find that the scheduled right arm award made on reconsideration is supported by the medical evidence in the record; specifically, by the PCE and Dr. Weinman's concurrence with that examination. (See Exs. 20, 22). Accordingly, we reverse that portion of the Referee's order which found claimant not entitled to a scheduled permanent disability award. Instead, we reinstate the scheduled award made by the March 24, 1993 Order on Reconsideration.

Because we have reinstated the scheduled award made by Order on Reconsideration, our order results in increased compensation. Therefore, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation. ORS 656.386(2); OAR 438-15-040(1).

Unscheduled Permanent Disability

After our review of the record, we agree with the Referee's determination that claimant is not entitled to an additional unscheduled permanent disability award for her right shoulder, because the right shoulder condition has not permanently worsened since the last arrangement of compensation. Accordingly, we adopt and affirm that portion of the Referee's order affirming the Order on Reconsideration to the extent it awarded claimant no additional unscheduled disability for the right shoulder.

ORDER

The Referee's order dated July 19, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which declined to award claimant any scheduled permanent disability is reversed. The award of 41 percent (78.72 degrees) scheduled permanent disability for the loss of use or function of the right arm, as awarded by the March 24, 1993 Order on Reconsideration, is reinstated and affirmed. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation (41 percent unscheduled permanent disability) created by this order, not to exceed $3,000. The remainder of the Referee's order is affirmed.

May 18, 1994 Cite as 46 Van Natta 963 (1994)

In the Matter of the Compensation of
DOUGLAS R. BAAR, Claimant
WCB Case No. 92-13378
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Claimant has requested reconsideration of that portion of our April 20, 1994 Order on Review which upheld the SAIF Corporation's denial of his claim for a hypertension condition. Specifically, claimant contends we erred in concluding that he had not established that his compensable injury was the major contributing cause of his hypertension condition. After reviewing claimant's motion and memorandum in support as well as SAIF's response, we issue the following order.

Claimant contends that Dr. Francis' opinion establishes that the compensable injury is the major contributing cause of his hypertension condition. However, as noted in our prior order, Dr. Francis states that the compensable injury and the attendant claims processing are the major cause of claimant's hypertension. (Ex. 17, 29). Dr. Francis did not opine that the compensable injury (without the claims processing) was the major contributing cause of claimant's hypertension. Consequently, we continue to adhere to our previous conclusion that claimant has not established that his compensable injury is the major contributing cause of his hypertension condition. See Hicks v. Spectra Physics, 117 Or App 293 (1992).

Accordingly our April 20, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHERRY Y. DROBNEY, Claimant
WCB Case No. 93-00292
ORDER ON RECONSIDERATION
Francesconi & Busch, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

On February 24, 1994, we withdrew our January 26, 1994 order that reversed a Referee's order affirming a Director's order under ORS 656.327(2) which had found claimant's right leg surgery to be inappropriate. We took this action to consider claimant's request for an attorney fee award under ORS 656.386(1). The parties were also granted an opportunity to submit further argument regarding claimant's request. Inasmuch as those arguments have been received, we proceed with our reconsideration.

The relevant facts are as follows. The employer requested Director review under ORS 656.327 of claimant's eighth right ankle surgery. The employer contended that the surgery was excessive, inappropriate and ineffectual. Following review, the Director found that the surgery was not appropriate for claimant's right ankle condition. Consequently, the Director held that the employer was not required to provide reimbursement for the surgery.

Claimant requested a hearing from the Director's order, arguing that the decision was not supported by substantial evidence. At the hearings level, the employer sought affirmance of the Director's order. In doing so, the employer did not assert that the surgery was unrelated to claimant's compensable right ankle condition. Reviewing for substantial evidence, the Referee affirmed the Director's order.

Claimant requested Board review. On review, the employer responded that the Referee's decision should be affirmed. Concluding that the Director's order was not supported by substantial evidence, we set the order aside and found that the employer was responsible for the surgery. Sherry Y. Drobney, 46 Van Natta 133 (1994). Our order did not grant an attorney fee.

Asserting that she has finally prevailed from a decision denying compensation, claimant seeks a carrier-paid attorney fee award under ORS 656.386(1). On reconsideration, we conclude that claimant is entitled to such an attorney fee award.

In Gwen A. Jackson, 46 Van Natta 357 (1994), on recon 46 Van Natta 822 (1994), we recently examined the court's plurality opinion in SAIF v. Allen, 124 Or App 183 (1993), which addressed the applicability of ORS 656.386(1). Reasoning that neither the "lead" nor concurring opinion were of precedental value because there was no majority opinion, we reexamined the relevant Supreme Court decisions for further guidance in analyzing the application of ORS 656.386(1). Based on our review of those decisions (Short v. SAIF, 305 Or 541 (1988), and Shoulders v. SAIF, 300 Or 606 (1986), among others), we determined that a claimant was entitled to an attorney fee award under ORS 656.386(1) for finally prevailing against an order or decision denying a medical services claim. We identified the critical inquiry as whether the carrier's conduct constitutes a decision denying the claimant's claim for compensation.

In Jackson, the carrier notified the claimant and her physician that a proposed surgery was excessive, inappropriate and ineffectual treatment. Recommending that the physician withdraw the surgery request, the carrier further advised that if the request was not withdrawn the physician should seek Director review under ORS 656.327. When the claimant requested a hearing, the carrier's position at hearing was that the proposed surgery was neither reasonable nor necessary. The carrier did not dispute that the surgery was causally related to the claimant's compensable condition.

Notwithstanding the carrier's notice that it had not and would not issue a denial of the proposed treatment, we reasoned in Jackson that the carrier's response to the physician's surgery request and its position at hearing constituted a "decision denying the claim for compensation." Inasmuch as we found the surgery to be appropriate, we held that the claimant was entitled to a carrier-paid attorney fee award under ORS 656.386(1) for her counsel's services at hearing and on review.

Here, as in Jackson, the employer has not contested the causal relationship between claimant's medical services claim and his compensable condition. Also, as in Jackson, the employer has challenged claimant's entitlement to such services, contending that the surgery was not appropriate. However, unlike Jackson, this case arises under the Director review procedures set forth in ORS 656.327.

Pursuant to ORS 656.327(1)(c), the carrier is precluded from denying the medical services claim and the worker is prohibited from requesting a hearing until issuance of the Director's order. In the event that the Director's order declares the treatment to be not compensable, the worker is not obligated to pay for such treatment. ORS 656.327(2). In addition, as a dissatisfied party, the worker is entitled to request review of the Director's order under ORS 656.283 in accordance with expedited review procedures. Id.

Inasmuch as a carrier is statutorily precluded from denying a medical services claim which is subject to the review procedures of ORS 656.327, the employer's refusal to pay for claimant's surgery claim does not represent a decision denying a claim for compensation. On the other hand, the Director's order declaring the medical treatment to be not compensable, as well as the Referee's order affirming the Director's decision, constitute orders denying claimant's medical service claim. Since claimant has initiated review of those decisions denying her claim for compensation and because she has finally prevailed, we hold that she is entitled to an attorney fee award under ORS 656.386(1) for her counsel's services at the hearing and on review.[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 regarding this claim is $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as modified herein, we republish our January 26, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] To the extent that our decision is inconsistent with any of the reasoning expressed in Robert P. Holloway, 45 Van Natta 2036 (1993), on recon 46 Van Natta 117 (1994), and Sherry A. Young, 45 Van Natta 2331 (1993), such reasoning is disavowed as contrary to the holding of Gwen A. Jackson, supra.

In the Matter of the Compensation of
PATRICIA A. JONES, Claimant
WCB Case No. 92-11878
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Westerband, Gunn, and Haynes.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish that her bilateral carpal tunnel condition, or the worsening of that condition, was caused in major part by her work activities. He, therefore, concluded that claimant's carpal tunnel condition was not compensable. We disagree.

Given the repetitive nature of claimant's work activities, we analyze her occupational disease claim under ORS 656.802(1)(c). Claimant must prove that work activities were the major contributing cause of her bilateral carpal tunnel syndrome. See ORS 656.802(2). A worsening of symptoms alone is insufficient unless the medical evidence establishes that the manifested symptoms are the disease. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

In the present case, claimant has been examined by numerous doctors. However, only Dr. Button, M.D., who specializes in hand surgery, has provided a cogent definition of a carpal tunnel syndrome. Dr. Button testified that carpal tunnel syndrome is a "collection of symptoms," rather than an underlying pathology. He stated that there is no single intrinsic disease process that causes carpal tunnel.

Dr. Becker, orthopedic surgeon, also provided an opinion which supports that of Dr. Button. Upon examination of claimant, Dr. Becker found no underlying disease process (e.g., rheumatoid arthritis, or gout) which would account for or contribute to the compromise in claimant's carpal tunnel. Dr. Becker reported that repetitive activities that involve carrying the wrists through extremes of motion tended to "augment or bring the carpal tunnel compromise to a symptomatic level." Dr. Becker concluded that claimant's work activities were the major cause of claimant's worsened carpal tunnel symptoms.

We are satisfied by the opinions of Dr. Button and Dr. Becker that claimant's carpal tunnel condition symptoms are the disease. In reaching this conclusion, we acknowledge that Dr. Button reported that carpal tunnel syndromes are more frequent in middle-aged females who are obese and have a history of hypertension. However, Dr. Button also stated that such individuals have a "greater incidence of development" of carpal tunnel syndrome and were "more prone" to having edema or swelling.

We conclude, on this record, that the combination of gender, obesity and hypertension can be a factor in the development of carpal tunnel syndrome, but how it is a factor is still a matter of theory rather than scientific fact. Furthermore, to the extent the combination of age, obesity and sex is a factor in this case, the combination is a predisposition, rather than a cause, of claimant's carpal tunnel syndrome. It is well established that we do not consider a "predisposition" to be a disease or preexisting condition for purposes of proving an occupational disease claim, 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).

We, therefore, find that claimant has established that her carpal tunnel condition symptoms are the disease. Consequently, because claimant has proven that her symptoms worsened, her bilateral carpal tunnel condition is compensable.

With regard to the dissent's reliance on Dr. Nathan, even Dr. Button remarked:

> "* * * In addition, Dr. Nathan has a very unique view of carpal tunnel syndrome and I have never seen him relate it to any type of occupational exposure. He continually talks about some nebulous, mysterious, intrinsic disease process that is the cause of these neuropathies. This is far outside the mainstream of consensus regarding carpal tunnel syndrome." (Ex. 28-4).

We agree.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate and reply briefs, the hearing record 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 counsel might go uncompensated.

ORDER

The Referee's order dated July 29, 1993 is reversed. The SAIF Corporation's July 28, 1992 denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an assessed attorney fee of $4,500, to be paid by SAIF.

Board Member Haynes dissenting.

I would affirm the Referee's order which found that claimant had not established compensability of a bilateral carpal tunnel condition. I agree with the Referee's conclusion that, because this is not a case where external observation is important, deference should be given to the experts, rather than the treating doctor. See Allie v. SAIF, 79 Or App 284 (1986).

Here, Dr. Nathan, an expert in carpal tunnel conditions, has opined that claimant's work did not cause or worsen her carpal tunnel condition. Dr. Nathan explained that claimant's work activities involved the use of both hands equally, and therefore, if work was the major cause of her symptoms and need for treatment, "symmetric bilateral median neuropathy" would be expected. Accordingly, Dr. Nathan persuasively reasoned that, because claimant's occupational disease was asymmetrical in nature, while claimant's work activities involved mainly symmetrical use of her hands, work activity could not be the major cause of her condition. The majority has provided no reasons for not deferring to the expert opinion of Dr. Nathan in this case.

Additionally, the majority relies on Dr. Button's opinion to support compensability. However, Dr. Button has agreed with Dr. Nathan that claimant's disease was not caused or worsened in major part by her work. Furthermore, although Dr. Button stated that carpal tunnel is a collection of symptoms, he also stated that claimant does have "several underlying conditions" including thickened tissue and an "arthritic inflammatory process." Dr. Button does not believe that work contributed to claimant's pathology.

Finally, I disagree with the majority's rejection of consideration of certain factors as "predispositions." In Liberty Northwest Ins. Corp. v. Spurgeon, 19 Or App 566, 569 (1991), the court held that if a claimant develops a disease in major part because of factors personal to her that are independent of any activities or exposure either off or on the job, the claim is not compensable, even if work contributed to some degree to causing the disease. All causes of a disease, as opposed merely to a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause. Id at 569.

Here, although Dr. Button opined that women were more likely to develop carpal tunnel syndrome than men, his further testimony clarified that he is speaking of actual causes of carpal tunnel. For example, Dr. Button referred to the "hormonal changes of menopause," "changes that might occur related to the carpal tunnel region as far as the lining tissues," and obesity and a greater body weight as causing "a greater load on the cardiovascular system." Ex. 32.

Dr. Button also testified that, when discussing hypertension, obesity and age, he was discussing factors that could cause carpal tunnel syndrome independent of work activities. Dr. Button stated that the factors actually caused the syndrome itself and the symptoms themselves, and he believed that this "applies in this individual, in particular relative to the hypertension and also the fact that she has an inflammatory arthritic process that has been ongoing off and on for sometime." Ex. 32-17.

Thus, I believe that the majority has erred by selecting portions of Dr. Button's testimony to rely upon, rather than considering his opinion in its entirety. Dr. Button's opinion clearly establishes that claimant developed the disease in major part because of factors personal to her that are independent of any activities or exposures either off or on the job and caused or contributed to her condition. Therefore, claimant's claim is not compensable, even if work contributed to some degree to causing the disease.

For the aforementioned reasons, I respectfully dissent. The Referee's order should be affirmed.

In the Matter of the Compensation of
KAREN T. MORRIS, Claimant
WCB Case No. 92-15896
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Hall, Westerband and Haynes.

Claimant requests review of that portion of Referee Barber's order which upheld the employer's denial of her bilateral wrist condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the findings of ultimate fact. Instead, we make the following findings of ultimate fact.

Claimant failed to prove that she sustained a discrete work injury to her left wrist in October 1991.

Claimant's bilateral tenosynovitis condition was caused in major part by her work activities.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to establish, by a preponderance of the evidence, that she sustained a discrete injury to her left wrist at work in October 1991. We agree. However, we find that claimant has proven that her bilateral tenosynovitis is compensable as an occupational disease.

In order to establish compensability of an occupational disease claim, claimant must prove, by a preponderance of the evidence, that work activities were the major contributing cause of the disease or its worsening. ORS 656.802(2). The occupational disease must be established by medical evidence supported by objective findings. Id. Because of the repetitive nature of claimant's work activities, we analyze this claim under ORS 656.802(1)(c).

Because of the delay between the allegedly causative work activities and the filing of this claim, combined with the existence of other intervening, potentially causative activities and conditions, we find that the question of causation is medically complex. Therefore, we require expert medical evidence to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Constien began treating claimant's bilateral wrist condition in February 1992. Upon examination, he found symptoms of bilateral de Quervain's tenosynovitis, which were supported by objective test findings. (See Exs. 4, 30). Dr. Constien treated claimant's tenosynovitis condition until it resolved in August 1992. (Ex. 4-8). He opined that claimant's work activity lifting files was the major contributing cause of the condition, and that the condition was unrelated to her pregnancy. (Exs. 27, 30).

Dr. Button, hand surgeon, examined claimant in October 1992 at the employer's request. Claimant's symptoms had resolved at that time, but he did not dispute Dr. Constien's diagnosis. (Exs. 24-3; 32-8). Dr. Button opined that it would be difficult to attribute claimant's past symptoms to her work activities. Rather, he believed that the hormonal and weight changes associated with pregnancy were a more important factor in the development of claimant's symptoms than her filing activities. (Ex. 24-4). However, in his subsequent deposition, Dr. Button conceded that claimant's work activities possibly could have caused tenosynovitis. (Ex. 32-7, -15). He also opined that the condition was unrelated to claimant's pregnancy. (Ex. 32-14, -17).

When medical opinion is divided, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no such reasons in this case. We do not find that Dr. Constien changed his opinion over time without explanation, as the employer asserts. Rather, we find that Dr. Constien's opinion became more definitive over time. By contrast, we find Dr. Button's ultimate conclusion to be less persuasive, because his opinions regarding the causative role of claimant's pregnancy were inconsistent. Moreover, claimant's job duties involved the kind of activities that, according to Dr. Button, can cause such a condition to develop; and to that extent, Dr. Button's opinion supports claimant's case. Accordingly, we

conclude that claimant has established the compensability of her occupational disease claim for bilateral tenosynovitis.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the self-insured employer. 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 July 12, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the employer's November 12, 1992 denial of a bilateral tenosynovitis condition is reversed. The employer's November 12, 1992 denial is set aside and the claim is remanded to the employer for processing in accordance with law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting.

I agree with the majority that claimant failed to prove that she sustained a work injury to her left wrist in October 1991. However, because I conclude that claimant also failed to prove that work activities were the major contributing cause of her occupational disease claim for her bilateral wrist condition, I dissent.

Claimant must prove that her work activities were the major contributing cause of her bilateral wrist condition. ORS 656.802(1)(c), (2). "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 Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem 111 Or App 666 (1992).

Dr. Button opines only that it is possible that claimant's work activities lifting files caused her tenosynovitis condition. Claimant must prove more than just the possibility of a causal connection. She must establish medical causation in terms of reasonable medical probability. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Dr. Constien opines that work activities were the major contributing cause of claimant's wrist condition. However, I find his opinion neither persuasive nor sufficient to carry claimant's burden of proof.

During the course of treatment, Dr. Constien's chart notes never mentioned even a possible work connection . (Ex. 4). Dr. Constien concurred with Dr. Button's report, except that he believed that it was more likely that claimant's work activities, rather than her pregnancy, caused her wrist condition. (Ex. 27). Finally, Dr. Constien offered the opinion that "[i]t appears clear to me that the tenosynovitis was, indeed, related to her job activities at work, lifting files." (Ex. 30).

Dr. Constien gave no explanation for the change in his opinion, from agreeing with Dr. Button that it would be difficult to attribute claimant's symptoms to her work activity, to stating it is "clear" that her condition was related to her work activities. I find Dr. Constien's opinion to be conclusory, inconsistent and devoid of explanation for the shifts in his opinion. Under such circumstances, I find there are persuasive reasons not to defer to Dr. Constien's opinion.

Moreover, were I to defer to Dr. Constien's opinion, I would still find his opinion insufficient to carry claimant's burden of proving that work activities were the major contributing cause of her condition. Dr. Constien specifically considered only the relative contributions of claimant's work activity and her pregnancy. His chart notes mentioned no potentially contributory work activities, but they did mention home activities related to caring for her newborn child. (See Ex. 4-1, 4-7). Claimant first treated for wrist symptoms while she was off work following the birth of her child, and her symptoms persisted while she was off work. (See Exs. 3A, 4, 5). Yet, Dr. Constien offered no opinion regarding

potentially causal off-work activities. Under these circumstances, I would conclude that Dr. Constien's opinion failed to establish that claimant's work activities contributed to her wrist condition more than all other causative agents combined.

Accordingly, because I believe claimant failed to carry her burden of proving that work activities were the major contributing cause of her bilateral wrist condition, I would affirm the Referee's order.

May 19, 1994 Cite as 46 Van Natta 970 (1994)

In the Matter of the Compensation of
MICHAEL L. COLE, Claimant
WCB Case No. 92-10165
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Livesley's order that upheld the self-insured employer's denial of claimant's bilateral wrist injury claim. On review, the issue is subjectivity.

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

The first determination to be made in this subjectivity case is whether claimant is a "worker" within the meaning of ORS 656.005(28). See S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994). "The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test." (Id., Slip Op. p. 20).

The factors to be considered under the traditional "right to control" test include: (1) direct evidence of the right to or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire at will without liability. Woody v. Waibel, 276 Or 189 (1976).

In this case, we find no evidence that OTS had or exercised control over claimant's work on the date of his injury. Similarly, we find no evidence that OTS furnished equipment for claimant's July 6, 1992 work on his father's roof and no evidence that OTS had the right to fire claimant from that job. Although it is true that OTS paid claimant for his work on that day, we also note that OTS subsequently contended that payment was in error. Under these circumstances, we are not persuaded that claimant worked for OTS on July 6, 1992 as required by ORS 656.005(28). Accordingly, we also agree with the Referee that claimant has not established that he was a "subject" worker when he was injured. See also ORS 656.027, especially §§2.

ORDER

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

In the Matter of the Compensation of
KATHLEEN P. FARLEY, Claimant
WCB Case No. 93-02894
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The self-insured employer requests review of those portions of Referee Davis' order which: (1) directed it to pay claimant the Order on Reconsideration's award of 17 percent (54.4 degrees) unscheduled permanent disability; (2) awarded claimant's counsel an assessed attorney fee of $1,500; and (3) assessed a 25 percent penalty for the employer's allegedly unreasonable refusal to pay the permanent disability award. Claimant cross-requests review of that portion of the order which reduced her award of unscheduled permanent disability for a low back injury from 17 percent (54.4 degrees), as granted by an Order on Reconsideration, to zero. On review, the issues are stay of compensation, penalties and 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 his "Findings of Ultimate Fact." We also offer the following summary of the relevant facts.

Claimant, a certified nurse's aide, sustained a compensable low back strain when she was kicked by a patient, causing her to strike a night stand. The claim was closed by a November 12, 1992 Determination Order, which awarded temporary disability but no permanent disability. Claimant sought reconsideration. After undergoing a medical arbiters' examination, which documented some reductions in lumbar range of motion, a January 28, 1993 Order on Reconsideration awarded 17 percent unscheduled permanent disability based on the arbiters' findings.

On February 10, 1993, the employer sought reconsideration of the Order on Reconsideration by letter to the Appellate Review Unit. The letter did not reach the Appellate Unit and was later faxed to the appropriate reviewer on March 9, 1993. On March 16, 1993, reconsideration was denied.

The employer requested a hearing on April 7, 1993, challenging the unscheduled permanent disability award granted in the reconsideration order. Meanwhile, payment of the unscheduled award was stayed pending the employer's appeal of the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

The Referee held that claimant was not substantively entitled to permanent disability awarded by the Order on Reconsideration. Specifically, the Referee found that the medical evidence was insufficient to establish that claimant sustained permanent impairment due to the compensable injury.

We agree, for the reasons outlined in the Referee's order, that claimant is not entitled to an award of permanent disability. We note that the medical arbiters documented reduced range of lumbar motion findings which they indicated were valid. (Ex. 32-3). However, we emphasize that the issue is not whether those range of motion findings were valid. Rather, the issue is whether those findings are the result of permanent impairment due to the compensable injury. See OAR 436-35-007(1). Because the attending physician, Dr. Stock, and the medical arbiters do not opine that claimant has permanent impairment due to the compensable injury, we decline to award claimant unscheduled permanent disability.

Stay of Compensation

Although he reduced claimant's award of permanent disability from 17 percent to zero, the Referee held that claimant's unscheduled award should have been paid within 30 days of the Order on Reconsideration, citing OAR 436-60-150(6)(c). This rule provides that permanent disability benefits are to be paid no later than the 30th day after "the date of any department order which orders payment of

compensation for permanent disability," unless the employer or insurer appeals the order pursuant to ORS 656.313. Finding that the obligation to pay claimant's award had matured prior to the request for hearing, the Referee ordered the employer to pay the 17 percent award.

The employer contends that the Referee erred in finding it could not stay payment of benefits, even though it did not request a hearing within 30 days of issuance of the Order on Reconsideration. It cites Gene G. Martin, 45 Van Natta 2102 (1993).

In Martin, the facts are similar to those in this case. There, a referee reversed an Order on Reconsideration that awarded permanent disability and reinstated a Determination Order which did not award any permanent disability. The Referee nevertheless directed the insurer to pay the claimant's permanent disability awarded by the Order on Reconsideration because the insurer had failed to request a hearing within 30 days of the order.

We reversed, citing Sisters of Providence v. East, 122 Or App 366 (1993), in which the court stated that OAR 436-60-150(6) applied to requests for reconsideration and that ORS 656.313 applied to appeals of a reconsideration order.[1] We concluded that payment of the claimant's permanent disability award was stayed pursuant to ORS 656.313 even though the insurer did not request a hearing within 30 days of the reconsideration order. We also agreed with the insurer's contention that it should not be required to pay a permanent disability award which was subsequently reversed on appeal and to which the claimant had no substantive entitlement. 45 Van Natta at 2103.

Like the claimant in Martin, claimant here is not substantively entitled to an award of permanent disability granted by the reconsideration order. Accordingly, based on our holding in Martin, we reverse the Referee's decision ordering the employer to pay claimant's permanent disability award in the reconsideration order.

Penalties and Attorney Fees

The Referee awarded an assessed attorney fee for claimant's counsel's assistance in obtaining payment of the 17 percent permanent disability award. In light of our decision discussed above, we reverse the Referee's award.

The Referee also awarded a 25 percent penalty based on the full amount of the 17 percent permanent disability award, finding that the employer's failure to pay claimant's award was unreasonable. Relying on our decision in Pascual Zaragoza, 45 Van Natta 1221 (1992), aff'd mem 126 Or App 544 (1994), we also held in Gene G. Martin, supra, that the insurer's failure to pay permanent disability awarded by an Order on Reconsideration was unreasonable where no request for hearing was filed within 30 days of issuance of the order. 45 Van Natta at 2104.

The language of OAR 436-60-150(6) clearly and unambiguously required the employer to pay the permanent disability awarded by any department order within 30 days, unless the order was appealed. The employer did not appeal within 30 days, and did not pay any portion of the award prior to its hearing request (which ws filed approximately 69 days after the reconsideration order). Because the employer failed to comply with the Department's rule, we affirm the Referee's penalty assessment based on the full amount of the permanent disability benefits the Order on Reconsideration awarded which were due following the expiration of the 30-day period from the Order on Reconsideration and prior to the employer's subsequently filed hearing request. See Lydia L. Kent 44 Van Natta 2438, 2441 (1992).

ORDER

The Referee's order dated July 30, 1993 is reversed in part and affirmed in part. Those portions of the Referee's order which ordered the employer to pay the award of permanent disability in the Order on Reconsideration and awarded an assessed attorney fee are reversed. The remainder of the Referee's order is affirmed.

[1] ORS 656.313(1)(a) provides that "Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for Board review or court appeal stays payment of the compensation appealed..."

In the Matter of the Compensation of
STEVEN D. GOUCHER, Claimant
WCB Case No. 93-03521
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Menashe's order that upheld the insurer's partial denial of claimant's left shoulder arthritic condition and associated need for shoulder replacement surgery. In addition, claimant moves the Board for an order remanding the case to the Referee for the 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

On review, claimant contends that the Referee erred in declining to reopen the record to admit proposed Exhibit 50, a July 1, 1993 report from Dr. Gillespie, examining orthopedic surgeon. Claimant also contends that, because of this error, the record was not "fully" developed. We disagree.

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). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence 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). However, before we address claimant's remand motion, we first respond to claimant's contention that the Referee erred in declining to admit Dr. Gillespie's report.

OAR 438-07-025(1) allows a Referee discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that a party moving for reconsideration must provide an explanation why such new evidence could not reasonably have been discovered and produced at the hearing. Renia Broyles, 42 Van Natta 1203 (1990). We review the Referee's evidentiary rulings for abuse of discretion. Id.

Here, claimant requested reconsideration of the Referee's June 28, 1993 order and moved to have the record reopened for inclusion of an additional report from Dr. Gillespie and the medical arbiter's report. In response, the Referee abated his order and allowed the insurer an opportunity to respond. On August 2, 1993, the Referee issued an Order on Reconsideration in which he granted claimant's motion to reopen the record, admitted the medical arbiter's report, did not admit Dr. Gillespie's report, and adhered to his June 28, 1993 order.

In requesting that Dr. Gillespie's report be admitted, claimant indicated that, subsequent to the closing of the record, he had submitted Exhibit A (impeachment evidence) to Dr. Gillespie, and had now received a response. Claimant argued, therefore, that this "later discovered document" had not been available at the time of hearing. The Referee reasoned that Exhibit A was available before hearing and could have been provided to Dr. Gillespie in order to generate a timely exhibit. We agree. Furthermore, if a party wishes to have a physician reconsider his opinion in light of new evidence introduced at hearing, the remedy is to request that the record be left open to receive the additional evidence. See Elizabeth E. Heller, 45 Van Natta 272 (1993).

We conclude that the Referee did not abuse his discretion in not admitting this evidence. Claimant has not offered a sufficient explanation as to why this report could not have been obtained prior to the closing of the record. The Referee was within his discretion in declining to admit proposed Exhibit 50.

With regard to claimant's motion for remand, we are not persuaded, in light of the circumstances described above, that Dr. Gillespie's report was not obtainable with due diligence at the time of the hearing. In particular, although Exhibit A was not made available to claimant prior to hearing, there can be no dispute that claimant's earlier medical records, which comprise Exhibit A, were available before hearing. Furthermore, the fact that Dr. Gillespie had not reviewed those records when he rendered his initial opinion was ascertainable at the time of hearing. Therefore, before and at the time of hearing, claimant's counsel was not prevented from supplying claimant's earlier treatment records to Dr. Gillespie, learning whether they affected his opinion, and obtaining an opinion that considered those records. Consequently, we are likewise unpersuaded that a compelling reason exists to remand for additional evidence taking. Accordingly, we deny claimant's remand motion.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following clarification.

The June 26, 1993 report of the Medical Ops Management physicians was a medical arbiter's examination, rather than an independent medical examination.

ORDER

The Referee's order dated June 28, 1993, as reconsidered on August 2, 1993, is affirmed.

In the Matter of the Compensation of
J. ALBERT JOHNSON, SR., Claimant
WCB Case Nos. 92-16276 & 91-11993
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Quillinan's order that: (1) upheld the self-insured employer's denial of an aggravation claim for a low back condition; (2) upheld the employer's denial of claimant's current left elbow condition; (3) upheld the employer's denial of claimant's pain center evaluation and mileage reimbursement allegedly incurred by claimant to obtain medical treatment; and (4) declined to assess penalties and attorney fees for these denials. The employer cross-requests review of that portion of the order that set aside its denial of claimant's office visits to a consulting physician. On review, the issues are aggravation, compensability of a current condition, jurisdiction, medical services, mileage reimbursement, penalties and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the finding that claimant returned to Oregon on August 22, 1992 and saw Dr. Golden on August 24, 1992. We, instead, find the following.

Sometime in mid-August 1992, claimant asked the employer to authorize vacation for claimant for the period August 30, 1992 through September 5, 1992. Claimant planned to use this vacation time to attend a September 1, 1992 settlement conference in an unrelated lawsuit. (Tr. 38-39, 47, 57-58). After scheduling this vacation, claimant took sick leave for the period August 23, 1992 through August 29, 1992. (Ex. 88a; Tr. 33). On or around August 25, 1992, claimant made an appointment to see Dr. Golden while claimant was in Oregon for the settlement conference. (Tr. 49, 65). Claimant traveled to Oregon on or around August 27, 1992. (Ex. 77A and B). Claimant was examined by Dr. Golden on August 31, 1992. (Ex. 79)

FINDINGS OF ULTIMATE FACT

Claimant did not sustain a direct injury to his left elbow at the time of his 1988 car accident.

The pain center evaluation and office visits denied by the employer were palliative rather than curative in nature. These medical services were not necessary to monitor administration of prescription medication required to maintain claimant in a medically stationary condition. Nor were these services provided to monitor a prosthetic device. Claimant is not permanently and totally disabled.

Claimant was in Oregon on personal business when he was examined by Dr. Golden on August 31, 1992.

CONCLUSIONS OF LAW AND OPINION

Aggravation of Low Back Condition

We affirm the Referee's decision upholding the employer's denial of claimant's aggravation claim for his low back condition. We do so, however, based on the following reasoning.

To prevail on his aggravation claim, claimant must show a worsened condition resulting from his 1988 injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991).

The Referee concluded that the last arrangement of compensation was the April 29, 1991 Determination Order, which the Referee found was claimant's last opportunity to present evidence on his behalf. (Ex. 47). Subsequent to the Referee's order, we concluded that reliance on a claimant's "last opportunity to present evidence" regarding his condition is ill-suited for conducting an aggravation analysis under the current statutory scheme, which provides for mandatory reconsideration by the Department. Lindon E. Lewis, 46 Van Natta 237 (1994). In Lewis, we held that evidence regarding the "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1).

Here, claimant requested reconsideration of the April 29, 1991 Determination Order, and an Order on Reconsideration issued on August 27, 1991. (Ex. 50). Claimant alleges a "post-reconsideration" worsening of his condition on July 9, 1992. Accordingly, per our rationale in Lewis, we conclude that the last award or arrangement of compensation was the August 27, 1991 Order on Reconsideration.

We must, therefore, determine whether claimant has sustained an injury-related worsening since August 27, 1991. The medical records do not establish a pathological worsening of claimant's low back condition. Claimant's aggravation claim is, instead, based on increased subjective symptoms. Claimant contends that his increased symptoms prevent him from ever returning to truck driving, whereas he had successfully performed that job prior to July 1992. (Ex. 75, 76, 80A-2; Tr. 28-30, 33, 37, 40).

We conclude that claimant has not established that his symptomatic worsening is causally related to his compensable injury. Claimant's symptoms are largely due to functional overlay. There is no persuasive medical evidence that claimant's functional overlay is causally related to his physical injury. (Ex. 76a, 79, 80a, 80A-2, 88, 89-18 through 19, 89-35; 91-30/31).

Furthermore, claimant's increased symptoms include falling episodes and bowel/bladder dysfunction that claimant has not established are causally related to his injury. With regard to the falling episodes, claimant relies on Dr. Holmes' opinion that the falls are attributable to a combination of claimant's injury residuals, pain syndrome and emotional/vocational impasse. (Ex. 80A-3). As noted above, claimant has not established that his functional overlay is compensable. Thus, Dr. Holmes' opinion does not establish that claimant's falling episodes are a compensable consequence of his injury. ORS 656.005(7)(a)(A).

Accordingly, on this record claimant has not proven that his symptomatic exacerbation is due to his compensable injury, as distinct from his functional overlay.

Jurisdiction/Medical Services

Claimant contends that the Referee erred in upholding the employer's denial of claimant's pain center evaluation by Dr. Holmes in October 1992. (Ex. 80A). The employer cross-requests review of the Referee's ruling that claimant's office visits to Dr. Golden, a consulting physician, in July, August and September 1992 are compensable. (Ex. 76, 79, 80a).

The medical services at issue here were provided for claimant's compensable low back condition. The Referee's order characterizes these services as palliative care. We have concluded above that claimant has not established a compensable aggravation of his low back condition. Claimant does not contend that his pain center evaluation and office visits to Dr. Golden are "curative" absent a compensable aggravation of the low back condition. On this record, we conclude that the medical services at issue here are palliative in nature.

The Director has exclusive jurisdiction over disputes regarding palliative care that is not otherwise compensable under ORS 656.245(1)(b) because it is provided to a worker who has been determined to have permanent total disability, is necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition, or is provided to monitor a prosthetic device. OAR 436-10-041(1). Hathaway v. Health Future Enterprises and SAIF Corporation, 125 Or App 549 (1993); Daniel K. Bevier, 46 Van Natta 41, on recon 46 Van Natta 215 (1994), on recon 46 Van Natta 909 (1994).

Here, the record does not establish that claimant's pain center evaluation and office visits fall within one of the exceptions set forth at ORS 656.245(1)(b).

In particular, the record does not establish that claimant's August 31, 1992 visit to Dr. Golden was necessary to monitor administration of prescription medication required to maintain claimant in a medically stationary condition. Claimant did testify that he scheduled this visit to Dr. Golden, in part, to obtain medication to enable claimant to continue working. (Tr. 33, 36, 38-39, 57-58.) However, Dr. Golden's report of the August 31, 1992 examination makes no reference to prescribing or monitoring medication. (Ex. 79). Furthermore, a September 9, 1992 note from claimant's treating physician, Dr. Andresen, suggests that Dr. Andresen was responsible for prescribing and monitoring claimant's medication. (Ex. 79A-3). On this record, we are not persuaded that the August 31, 1992 visit to Dr. Golden was necessary to monitor claimant's prescription medication within the meaning of ORS 656.245(1)(b).

In summary, we conclude that the palliative care services at issue here are beyond the jurisdiction of the Referee and the Board. We, therefore, vacate the Referee's conclusions and opinion regarding the employer's denial of claimant's pain center treatment and office visits to Dr. Golden.

Compensability of Left Elbow Condition/Mileage Reimbursement/Penalties and Attorney Fees

We adopt and affirm the Referee's conclusions and opinion regarding compensability of claimant's left elbow condition, mileage reimbursement and penalties and attorney fees.

ORDER

The Referee's order dated May 20, 1993 is affirmed in part and vacated in part. Those portions upholding the employer's medical services denials are vacated. The Referee's award of a $750 attorney fee for services at hearing regarding these medical services denials is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DALE A. KARSTETTER, Claimant
Own Motion No. 93-0050M
OWN MOTION ORDER ON RECONSIDERATION
Stebbins & Coffey, Claimant Attorneys
Saif Legal Department, Defense Attorneys

Claimant requests reconsideration of our February 16, 1993 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he had not established he required surgery or hospitalization for the compensable injury. In his request for reconsideration, claimant contended that surgery was performed, and requested additional time to establish the relationship of his compensable injury to the surgery.

On December 10, 1992, the SAIF Corporation, as the own motion insurer, denied the compensability of and responsibility for claimant's current condition. In an order dated March 3, 1993, we withdrew and abated our February 16, 1993 Own Motion Order and postponed action on the own motion request pending the outcome of a hearing on related issues. WCB Case No. 92-16156.

In an Opinion and Order issued April 6, 1993, Referee Howell set aside that portion of SAIF's December 10, 1992 denial which denied compensability of claimant's current low back condition, and affirmed SAIF's disclaimer of responsibility. The Referee concluded that a SAIF, as the insurer for a subsequent employer, is responsible for claimant's current compensable condition. By Order on Review issued January 27, 1994, the Board affirmed Referee Howell's April 6, 1993 order.

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

Here, the current condition and ensuing surgery for which claimant requests own motion relief, is the responsibility of a subsequent employer. Consequently, we are not authorized to reopen his claim at this time.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 16, 1993 order in its entirety. 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
GREG W. KOENIG, Claimant
WCB Case No. 92-14245
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The insurer requests review of those portions of Referee Crumme's order that: (1) awarded claimant temporary disability benefits for the period of June 12, 1990 through February 18, 1991; (2) assessed a penalty for allegedly unreasonable claim processing; and (3) increased claimant's unscheduled permanent disability for a low back condition from 25 percent (80 degrees) to 30 percent (96 degrees). On review, the issues are temporary disability, penalties, and extent of permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant has an accepted low back condition for which he has been awarded 25 percent unscheduled permanent disability. In May 1990, Dr. Bishop, claimant's current treating orthopedic surgeon, recommended surgery. A referee, in a prior proceeding, concluded that the surgery was compensable. The prior referee further found that the issue of entitlement to temporary disability was not "ripe" and so did not address the matter.

On February 19, 1991, claimant underwent back surgery. A July 13, 1992 Determination Order awarded temporary disability for the period from February 19, 1991 through October 4, 1991 and no additional permanent disability. On reconsideration, the Determination Order was affirmed in its entirety.

The insurer has paid claimant temporary disability benefits commencing February 19, 1991.

ULTIMATE FINDING OF FACT

A preponderance of the evidence in the record shows that claimant was disabled on June 12, 1990, due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The Referee first found that claimant was not precluded from litigating entitlement to temporary disability benefits, due to the prior litigation. We agree, and we adopt the Referee's reasoning on that issue.

Turning to the merits of claimant's claim, the Referee affirmed the Determination Order's medically stationary date of October 4, 1991. The Referee further found that the Determination Order correctly awarded claimant temporary disability benefits from the date of his surgery, February 19, 1991, through the medically stationary date of October 4, 1991. Furthermore, the Referee found that claimant had established entitlement to additional temporary disability benefits. Specifically, the Referee held that claimant had proven that he was entitled to temporary disability benefits beginning from the onset of disability, which was June 12, 1990. We agree.

On review, the insurer contends that the Referee erred in awarding claimant temporary disability benefits beginning June 12, 1990. The insurer argues that there is no evidence that claimant established an aggravation claim as of that date.

We do not find the dispositive inquiry on this issue to be whether an aggravation claim was filed by claimant. In that regard, the insurer's payment of temporary disability commencing with claimant's compensable surgery constitutes a reopening of the claim for a worsened condition; i.e., an aggravation claim. Once the claim has been reopened, the insurer is responsible for processing the claim to closure. See ORS 656.273(6); 656.268. In processing the claim, the insurer is obligated to begin payment of claimant's temporary disability on the accepted claim as of claimant's disability date. See Silsby v. SAIF, 39 Or App 555, 560-62 (1979); Gene T. LaPraim, 41 Van Natta 956 (1989).

Thus, we agree with the Referee that claimant is entitled to temporary disability benefits from the onset of disability until his condition is medically stationary. Such entitlement is proven by a preponderance of the evidence in the 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 (1992); Esther C. Albertson, 44 Van Natta 2058 (1992).

Although the insurer argues that claimant cannot prove that he was disabled prior to the February 1991 surgery, we agree with the Referee that claimant has proven an earlier onset of disability. On June 12, 1990, claimant was examined by Dr. Bills, M.D., his attending physician at that time. Dr. Bills reported that claimant had been having significant problems and, following his evaluation, Dr. Bills wrote to request reopening of the claim for further treatment. On August 14, 1990, Dr. Bills provided an authorization for time loss, indicating that time loss was authorized beginning June 12, 1990.

Based on the record as a whole, we conclude that claimant has established that he was disabled as of June 12, 1990. Accordingly, we affirm the Referee's award of additional temporary disability benefits, beginning upon that date.

The insurer also disagrees with that portion of the Referee's order that found that, by November 14, 1990, the insurer had received an aggravation claim and was required to begin paying claimant interim compensation benefits until it issued a denial.

We substitute that portion of the Referee's order with the following analysis.

Although the Referee and the parties refer to claimant's entitlement to benefits from November 14, 1990 through February 18, 1991, as an "interim compensation" issue, we disagree with such a characterization of those benefits.

Interim compensation benefits may be due if an insurer has neither accepted nor denied an aggravation claim. See, e.g., Richard L. Oviatt, 45 Van Natta 294 (1993). In the present case, however, claimant's surgery was found compensable by a prior referee, and the insurer was directed to process the claim.

In Gene T. LaPraim, supra, the Board distinguished compensable aggravation claims from cases involving noncompensable claims. In LaPraim, the Board held that Silsby v. SAIF, supra, stood for the proposition that once an aggravation claim has been accepted or found compensable, temporary disability compensation, as opposed to interim compensation, is due from the date of disability to the date the insurer received notice of a medically verified inability to work. In LaPraim, the Board reasoned that the cases subsequent to Silsby made it clear that interim compensation, as opposed to temporary disability compensation, is never owed on an aggravation claim for any period prior to the date upon which the insurer received notice of a medically verified inability to work. See e.g. Kosanke v. SAIF, 41 Or App 17, 21 n. 2 (1979). Consequently, in the present case, as in LaPraim, because claimant's aggravation claim is compensable, temporary disability, rather than interim compensation, is owed from the date of disability.

Therefore, although we do not find that claimant's entitlement to benefits stem from interim compensation, we agree with the Referee's alternative reasoning that claimant's temporary disability benefits must continue until the date upon which he was found to be medically stationary. We, therefore, affirm the Referee's award of temporary disability benefits from June 12, 1990 through February 18, 1991.

Penalty

The Referee found that claimant was entitled to a penalty for the insurer's unreasonable claim processing based on temporary disability benefits due from June 12, 1990 through February 18, 1991. We agree that a penalty should be assessed; however, we apply the following analysis.

As explained above, we consider the issue to be whether the insurer unreasonably failed to pay temporary disability benefits, rather than interim compensation benefits. Here, upon reopening of the claim, the insurer was required to determine claimant's date of disability, and to begin paying temporary disability benefits from that date. ORS 656.273(6); 656.268.

In light of Dr. Bills' time loss authorization, we conclude that the insurer's failure to pay claimant temporary disability benefits from the onset of disability, June 12, 1990, through the date of surgery (upon which date the insurer first commenced payment of benefits), was unreasonable. Accordingly, we conclude that claimant is entitled to a penalty of 25 percent of the amounts due from June 12, 1990 through February 18, 1991, to be shared equally by claimant and his attorney. ORS 656.262(10).

Extent of Permanent Disability

The Referee found that claimant was entitled to an award of 30 percent unscheduled permanent disability. We adopt and affirm this portion of the Referee's order.

Claimant's attorney is entitled to an assessed attorney fee for services on review regarding the temporary and permanent disability issues. 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 services on review regarding these issues is $800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of interest involved. We note that no attorney fee is available for that portion of claimant's brief devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated March 12, 1993 is modified in part and affirmed in part. The Referee's penalty award is modified. In lieu of the Referee's penalty assessment, the insurer shall pay claimant a penalty in the amount of 25 percent of the unpaid temporary disability benefits due from June 12, 1990 through February 18, 1991, with one-half of the fee paid to claimant's counsel in lieu of an attorney fee. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer.

In the Matter of the Compensation of
DIANE C. MARQUARDT, Claimant
WCB Case No. 92-12484
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Hoguet's order that: (1) upheld the insurer's denial of her occupational disease claim for mental stress; (2) declined to assess penalties for an allegedly unreasonable denial; and (3) failed to assess an attorney fee under ORS 656.386(1) for prevailing over a denial. On review, the issues are compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." We also adopt the Referee's "Ultimate Findings of Fact" with the exception of the last finding which concludes that claimant's "quality product" stress is not the major contributing cause of her need for medical treatment and disability in August 1992.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's psychological condition was not compensable. The Referee reasoned that the medical evidence did not adequately establish that work-related stressors, not otherwise excluded by ORS 656.802(2)(b), were the major contributing cause of claimant's August 1992 psychological condition.

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. The mental disorder must be recognized in the medical or psychological community. The employment conditions producing the mental disorder must exist in a real and objective sense. In addition, 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. Finally, there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(2) & (3). 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).

We agree with the Referee's opinion which finds that claimant suffers from a diagnosed mental disorder which is generally recognized in the medical/psychological community established by medical evidence supported by objective findings. In addition, we agree with that portion of the Referee's order

that finds claimant's mental disorder resulted in disability and the need for medical treatment. We further agree with the Referee's analysis which concludes the evidence is clear and convincing that claimant's mental disorder arose from employment conditions which existed in a real and objective sense.

In analyzing the different employment conditions which gave rise to the mental disorder, the Referee, for the sake of clarity, characterized the stressors as either "performance review" stressors or "quality product" stressors. "Performance review" stressors were defined as the psychological effects of claimant's negative job performance evaluations, related fear of losing her job, and inability to transfer to department due to the poor performance reviews.

"Quality product" stressors were defined as the difficulties claimant encountered in attempting to sell what she perceived to be poor quality products. Due to organizational changes involving the computer and work room consolidation, the product that claimant sold experienced marked deterioration. As a consequence, claimant's ability to sell and retain customers was significantly diminished. Finally, on August 3, 1992, claimant lost a $4,000 sales commission when a customer canceled a large order. The cancellation was due to the employer's inability to correct an unacceptable order on three separate occasions. The problems included a computer "foul up," work room problems, and difficulties with delivery and installation.

The Referee found the "performance review" stressors noncompensable because they were deemed to be reasonable disciplinary, corrective or job performance evaluation actions by the employer. The "quality product" stressors were found to be compensable because they were not statutorily excluded and not generally inherent in every working situation. In deciding whether "quality product" stressors or "performance review" stressors were the major contributing cause of claimant's psychological disorder, the Referee was troubled by the fact that the attending medical providers did not specify which group of stressors was the major contributing cause of claimant's disorder. In the absence of such specificity, the Referee concluded that claimant failed to carry her burden of proof of establishing that the "quality product" stressors were the major contributing cause of claimant's psychological condition. We disagree and reverse.

We briefly review the relevant facts. The day after she lost her large commission, claimant sought medical care for a stiff neck, headaches, and low back pain from chiropractic physician, Dr. Berry. He related her physical symptoms to work-related stress and released claimant from work. (Exs. 27, 28, 33). On August 12, 1992, claimant was seen by clinical psychologist, Dr. McNeil. (Ex. 35). Based upon her examination of claimant, it was the opinion of Dr. McNeil that claimant's psychological condition was related to issues surrounding "poor quality products." (Exs. 35, 43, 46). Claimant was also seen by internist, Dr. McNalley, for stress-related physical symptoms as well as for depression on August 25, 1992. (Ex. 20). Likewise, it was the opinion of Dr. McNalley that the relevant stressors concerned poor product quality. (Exs. 20, 47).

We note that neither medical provider stated explicitly in their clinical reports that "quality product" stressors were the major contributing cause of claimant's condition. However, it is not necessary to use "magic words" in order to satisfy the major contributing cause test. It is sufficient if the opinion supports the conclusion that compensable work-related stressors were the major contributing cause of claimant's condition. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). In any event, we note that both Drs. McNeil and McNalley concurred with a letter drafted by claimant's counsel that did include the necessary statutory language as well as a brief description of the "quality product" stressors. (Exs. 46, 47).

We further note that neither medical provider quantified the relevant contribution made by each stressor group. However, such an inquiry is primarily a legal one. We would not expect a medical provider to render an opinion on this issue unless asked to do so. In this case, the attending medical providers were never asked to directly compare the relative weight and contribution of "quality product" stressors with "performance review" stressors. Although certainly such an opinion would have been helpful to the inquiry, absence of such an opinion is not necessarily fatal to claimant's case.

In contrast is the opinion of Dr. Parvaresh, who examined claimant on behalf of the insurer, in December 1992. Based on his examination, it was his opinion that the major contributing cause of claimant's psychological condition was "performance review" stressors. (Ex. 45). At hearing, after being informed for the first time of the loss of the $4,000 sales commission on August 3, 1992, he seemed to modify his opinion. He testified that both "performance review" stressors and "quality

product" stressors were the major contributing cause of claimant's condition. (Tr. 203-205). Dr. Parvaresh clearly distinguished between the two types of stressors and stated at one point that the "quality product" stressors were the major cause of claimant's psychiatric condition. (Tr. 205). However, like the other medical providers, he was not asked and did not otherwise attempt to quantify and compare the contributions of the two stressor groups.

To the extent Dr. Parvaresh's opinion can be interpreted to say that "performance review" stressors were the major contributing cause, we do not find his opinion to be persuasive. The "performance review" stressors were primarily a factor in February and March 1992 when the corrective and disciplinary action was carried out. Although claimant did seek medical care in April 1992, Dr. Gadye's chart notes do not relate the need for care to "performance review" stressors. (Ex. 20-1-2). When claimant again sought medical care following the loss of the large order in August 1992, the chart notes of Drs. McNeil and McNalley do not emphasize "performance review" stressors as important causal factors.

Dr. Parvaresh only examined claimant once. In contrast, both Drs. McNeil and McNalley saw claimant on multiple occasions giving them ample opportunity to observe and evaluate claimant. In addition, we find that the attending medical providers had a complete and accurate history. Accordingly, finding no reason to disregard their opinions, we give more weight to the opinions of the attending medical providers. Weiland v. SAIF, 64 Or App 810 (1983).

Finally, we note that Dr. McNeil concurred in Dr. Parvaresh's December 1992 opinion which indicated that the major contributing cause was corrective or disciplinary measures. (Ex. 48). However, we also note that just prior to that concurrence she had indicated to claimant's counsel that "quality product" stressors constituted the major contributing cause. (Ex. 46). We do not find these differing positions necessarily inconsistent. Rather, we interpret Dr. McNeil to say that both stressor groups were significant. When these two reports are read in conjunction with the contemporaneous clinical reports authored by Drs. McNeil and McNalley, the obvious conclusion to draw is that the "quality product" stressors was clearly and convincingly the greater stressor group. Accordingly, we find that "quality product" stressors were the major contributing cause of claimant's psychological condition. Thus, the claim is compensable.

Penalties

Claimant next asserts that the insurer's September 8, 1992 denial of the compensability of claimant's psychological condition was unreasonable.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). Whether a denial is unreasonable depends upon whether a carrier has a legitimate doubt regarding its liability, based on the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Continuation of that denial can also become unreasonable if, and only if, new evidence destroys any legitimate doubt about liability. Id. at 592; Georgia-Pacific Corp. v. Arms, 106 Or App 343, 347 (1991).

Claimant argues that prior to issuance of the denial the insurer did not have a legitimate doubt regarding liability. In particular, claimant points to the fact that Dr. Parvaresh did not examine claimant until after the denial had issued. (Exs. 37, 45).

The record indicates that the December 12, 1991 denial of claimant's prior psychological condition had become final by operation of law. (Ex. 16). Following that, claimant continued to have difficulties with job performance evaluations and corrective action. (Exs. 17, 18, 19, 23, 24). Knowledge of the employer is imputed to the insurer. Thus, we find the insurer had information before it suggesting that claimant's stressors might be related to factors subject to the statutory exclusion under ORS 656.802. Therefore, we find the insurer had a legitimate doubt as to its liability. Dr. Parvaresh's December 1992 report would have further reinforced this doubt. (Ex. 45). Claimant is not entitled to penalties and attorney fees for an unreasonable denial.

Attorney Fees

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 fee for claimant's attorney's services at hearing and on review concerning the compensability issue is $7,500, 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, the value of the interest involved, and the risk that in a particular case that an attorney's efforts may go uncompensated.

ORDER

The Referee's order dated April 23, 1993, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's denial is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on Board review, claimant's counsel is awarded an assessed attorney fee of $7,500, to be paid by the insurer. The remainder of the order is affirmed.

May 19, 1994 Cite as 46 Van Natta 983 (1994)

In the Matter of the Compensation of
JUDITH M. MORLEY, Claimant
WCB Case No. 92-15147
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Claimant requests reconsideration of our May 6, 1994 order that affirmed Referee Baker's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for a left wrist/forearm condition; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable denial. Claimant argues that our reasoning with respect to the medical opinions of Drs. Lawton and Nathan is faulty.[1]

We have now received the insurer's response to claimant's request for reconsideration. We withdraw our May 6, 1994 order and proceed with our reconsideration.

Claimant argues that, because, at hearing, no one raised the issue of whether there were other possible causes of claimant's left wrist/forearm condition, we should not have considered that on review.

It is elementary that our de novo review encompasses all issues raised or raisable on the entire record before us regardless of whether those issues were raised by the parties on review. Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986); Donald A. Williams, 43 Van Natta 1892 (1991). Accordingly, although the parties in this case did not argue on review the issue of whether there existed other potential causes for claimant's condition, it was in our purview to consider that issue pursuant to our de novo review.

On reconsideration, however, we conclude that, in light of the record developed at hearing, and the fact that we have alternatively concluded that claimant has failed to establish that her work exposure was the major cause of the onset or worsening of a pathological condition involving her left forearm or wrist, it was unnecessary for us to have addressed the "other causes" issue. Therefore, we modify our prior order by deleting the fifth and sixth full paragraphs on page 3 of the order. We conclude that the remainder of claimant's contentions have been adequately addressed in our prior order.

Accordingly, on reconsideration, as supplemented herein, we republish our May 6, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant also argues that we incorrectly determined that her symptoms did not require medical services or result in disability sufficient to support a claim for compensation. Particularly, claimant argues that we improperly found that claimant had not received medical services for her left wrist/forearm condition. We made no such finding. Indeed, we expressly declined to decide the issue. (Order on Review at 2). Claimant further argues that, because the Referee found that claimant had reported left arm symptoms to her treating physician on two occasions, she necessarily received medical services for her left wrist/forearm condition. We again decline to address that issue because, even assuming that claimant had received medical services for her left wrist/forearm condition, her claim nevertheless fails for lack of sufficient evidence of causation.

In the Matter of the Compensation of
CASSANDRA V. POTTER, Claimant
WCB Case No. 93-07532
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of that portion of Referee Brazeau's order that awarded an assessed attorney fee of $1,200 for claimant's counsel's services in connection with SAIF's pre-hearing rescission of its "de facto" denial of claimant's claim for a thoracolumbar strain. Claimant requests an increased attorney fee. On review, the issue is attorney fees.

We adopt and affirm the Referee's order regarding claimant's entitlement to an attorney for her counsel's services in connection with SAIF's pre-hearing rescission of its "de facto" denial of claimant's claim for a thoracolumbar strain. See Wesley R. Craddock, 46 Van Natta 713 (1994).[1] In addition, we supplement the Referee's order as follows, concerning the amount of the fee.

Claimant requests an increased attorney fee, contending that the Referee improperly considered the fact that SAIF had paid all of claimant's compensation in determining an appropriate fee under ORS 656.386(1). We disagree.

In evaluating claimant's request, we consider the factors recited in OAR 438-15-010(4), noting that the value to claimant of the interest involved and the benefit secured for the represented party are but two of those factors. Accordingly, we also consider: (1) the time devoted to the case; (2) the complexity of the issue involved; (3) the skill of the attorneys; (4) the nature of the proceedings; (5) the risk in a particular case that an attorney's efforts may go uncompensated; and (6) the assertion of frivolous issues or defenses. Having considered these factors and applying them to this case, we find that the Referee's award of a $1,200 assessed attorney fee for services rendered prior to hearing is reasonable and appropriate.

Inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for his successful defense of the attorney fee on Board review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 23, 1993 is affirmed.

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[1] SAIF cites SAIF v. Allen, 124 Or App 183 (1993) rev allowed, 318 Or 478 (1994) in support of its contention that claimant is not entitled to an attorney fee under ORS 656.386(1). We recently examined the court's plurality opinion in Allen and found that the case lacks precedential value. Gwen A. Jackson, 46 Van Natta 356 (1994), on recon 46 Van Natta 822 (1994). Accordingly, for the reasons articulated in Jackson, we conclude that SAIF's citation does not aid its cause in the present case.

In the Matter of the Compensation of
JOHN J. RICE, Claimant
WCB Case No. 92-07253
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Schultz's order that upheld the insurer's denial of his medical services claim for low back surgery. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

On November 26, 1990, claimant underwent a lumbar laminectomy of L5 with lateral recess decompression and neurolysis. The surgery was performed by Dr. Nash. By a July 23, 1991 order, Referee Mills found that the November 26, 1990 surgery was compensable. Thereafter, the insurer appealed Referee Mills' order.

On November 25, 1991, Dr. Misko requested authorization to perform further surgery. The surgical procedure requested by Dr. Misko was a removal of lumbar disk, L5-S1, left, with laminectomy and a bilateral Steffee plate fusion, L5-S1.

On January 9, 1992, the insurer's claims examiner wrote claimant informing him that two independent medical examinations that the insurer had scheduled were being cancelled. In addition, the letter stated that "your claim is accepted and it is my understanding that surgery is pending." On February 13, 1992, claimant underwent the surgery requested by Dr. Misko.

On April 30, 1992, the Board issued an order which reversed that portion of Referee Mills' opinion which found that the November 26, 1990 surgery was compensable. John J. Rice, 44 Van Natta 928 (1992). The Board reinstated the insurer's denial of claimant's November 1990 surgery. On May 5, 1992, the insurer issued a denial of the February 13, 1992 surgery.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer had not accepted the February 13, 1992 surgery and on the merits found that the surgery was not compensable. We disagree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9).

The insurer contends that it did not accept the February 13, 1992 surgery, but rather was merely complying with its processing duties while the appeal of Referee Mills' order was pending. However, the issue before Referee Mills was the compensability of the November 26, 1990 lumbar laminectomy of L5 with lateral recess decompression and neurolysis performed by Dr. Nash. The February 13, 1992 surgery was not even requested until November 1991. It was performed by Dr. Misko and involved a different surgical procedure. Specifically, Dr. Misko performed a removal of lumbar disk, L5-S1, left, with laminectomy and a bilateral Steffee plate fusion, L5-S1. The insurer's appeal of Referee Mills' order did not relieve it of its duty to process the November 1991 request by Dr. Misko, particularly since it involved a different surgical procedure than that performed by Dr. Nash in November 1990.

After Dr. Misko had requested authorization for surgery in November 1991, the insurer's claims examiner cancelled scheduled independent medical examinations and expressly informed claimant that "your claim is accepted and it is my understanding that surgery is pending." Although the insurer's letter may not constitute a "formal" notice of claim acceptance, we conclude it was nevertheless a legal claim acceptance. See Shaun M. Donovan, 45 Van Natta 878, 880 (1993) (A letter from the carrier indicating that a psychological condition was considered part of the claimant's compensable claim constituted a legal acceptance of the psychological condition). Based on the letter from the insurer's claims examiner, we find that the insurer accepted claimant's medical services claim for the February 13, 1992 surgery. SAIF v. Tull, supra.

Inasmuch as we have found that the insurer accepted the February 13, 1992 surgery, claimant's arguments concerning the admissibility of the insurer's claims examiner's testimony concerning the insurer's intentions in drafting the "acceptance" letter are moot.

Although we have found that the insurer accepted the February 13, 1992 surgery, that does not end the inquiry. ORS 656.262(6) allows a carrier to deny an accepted claim within two years of the acceptance if it accepts the claim in good faith but later obtains evidence that the claim is not

compensable. "Later obtained evidence" has been defined as "requir[ing] new material, i.e., something other than evidence that the insurer had at the time of its initial acceptance." CNA Ins. Co. v. Magnuson, 119 Or App 282, 286 (1993). Reevaluation by the carrier of known evidence in light of a change in the case law, does not constitute "later obtained evidence" under the statute. Id; see also Patricia A. Hinsen, 45 Van Natta 1467 (1993), aff'd mem Merry Maids v. Hinsen 127 Or App 753 (1994) (reevaluation of where an injury occurred in light of subsequent court case indicating that domestic servants are excluded from workers' compensation coverage does not constitute "later obtained evidence" under ORS 656.262(6)). If claimant requests a hearing, the carrier must prove by clear and convincing evidence that the claim is not compensable. ORS 656.262(6).

At the time of its claim acceptance, the insurer was aware of the diagnosis of claimant's condition and surgery proposed by Dr. Misko to alleviate that condition. It had an independent medical examination report from Dr. Hardiman who opined that the February 1992 surgery was due to the compensable injury, the spondylosis and resultant surgeries. (Ex. 73C). Thereafter, the insurer cancelled two further independent medical examinations. Claimant's condition did not change between the acceptance and the insurer's subsequent denial. Rather, the insurer sought further medical opinions relating to the same condition. We do not find that these later medical opinions constitute "later obtained evidence."

In addition, at the time of its acceptance, the insurer was aware that its appeal of Referee Mills' order was pending. Reevaluation of the known evidence in light of a change in the result of Referee Mills' order likewise does not constitute "later obtained evidence" under the statute. Moreover, that appeal did not include the subsequent surgery request. Accordingly, the "back-up" denial must be set aside.

Finally, even if such evidence could be considered under the statute, it is questionable whether the employer has established, by clear and convincing evidence, that the February 13, 1992 surgery is not compensable. Dr. Nash, who performed the November 1990 surgery, reported that the 1989 compensable injury resulted in a total decompensation of stability due to the spondylolysis at the L5-S1. (Ex. 59). In addition, Dr. Nash noted that claimant had experienced neurological symptoms, attributable to L5-S1, since the 1989 injury. Id.

Dr. Hardiman initially reported that the February 1992 surgery was due to the compensable injury, the spondylosis and resultant surgeries. (Ex. 73C). Later, Dr. Hardiman, without explanation, concluded that the need for surgery was solely related to the prior November 1990 surgery. (Ex. 115). Finally, Dr. Arbeene, who also examined claimant at the request of the insurer, opined that if the November 1990 surgery was not work-related, then the February 1992 surgery should not be considered work-related. (Ex. 114).

Consequently, even if we considered such opinions as "later obtained evidence," in light of Dr. Nash's opinion and Dr. Hardiman's inconsistent opinions, we would not be inclined to conclude that the insurer had established by clear and convincing evidence, that claimant's February 1992 surgery was not compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $5,000, 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 and reply briefs and the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 22, 1993 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 award an assessed attorney fee of $5,000, payable by the insurer.

In the Matter of the Compensation of
KATHLEEN A. ROBINSON, Claimant
WCB Case No. 93-02515
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

On April 28, 1994, we issued our Order on Review that affirmed a referee's order upholding the self-insured employer's denial of claimant's surgery and related treatment for an L5-S1 herniated disc that claimant sustained during a medical examination performed on the employer's behalf. Claimant has requested reconsideration, arguing that our reasoning in this case is inconsistent with the Board's decisions in Billie I. Ensley, 46 Van Natta 417 (1994), on recon 46 Van Natta 704 (1994) and George Hames, Jr., 45 Van Natta 2426 (1993).

We have now received the employer's response to claimant's request for reconsideration. It appears that both parties were unaware of our recent Order on Reconsideration in Billie I. Ensley. Accordingly, to further consider claimant's contentions, we withdraw our April 28, 1994 order. The parties are simultaneously granted an opportunity to submit further argument regarding the effect, if any, the Board's Order on Reconsideration in Billie I. Ensley has on this matter. (A copy of the Ensley Order on Reconsideration is attached with this order.) To be considered, the parties' responses must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBBIE W. WORTHEN, Deceased, Claimant
WCB Case No. TP-93011
THIRD PARTY ORDER DENYING RECONSIDERATION
G. Jefferson Campbell, Claimant Attorney
Schwabe, et al., Defense Attorneys

Claimant, the personal representative for the estate of the deceased worker, requests reconsideration of our February 9, 1994 Third Party Distribution Order, which held that Lumbermen's Underwriting Association (LUA) was entitled to the remaining balance of proceeds from claimant's third party settlement with D-9 Construction ($6,115.45).[1]

Claimant has previously petitioned the Court of Appeals for judicial review of our February 9, 1994 order. Since the 30-day period within which to withdraw and reconsider our order has expired, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1); SAIF v. Fisher, 100 Or App 288 (1990). 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).

Contending that sole jurisdiction over distribution of the proceeds from the estate's wrongful death actions rests with the probate court, claimant argues that we lacked authority to address LUA's claim for a share of the "D-9" settlement proceeds. Reasoning that LUA's lien does not attach until the estate's proceeds have been distributed to workers' compensation "beneficiaries," claimant asserts that LUA will not be entitled to a share of proceeds because the costs incurred in the estate's prosecution of the "D-9" and "Navistar" causes of action exceed the total recovery from the settlement and judgment.

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[1] Claimant also seeks an Order staying enforcement of our decision pending claimant's appeal. We need not address such a request because our February 9, 1994 order is not enforceable. In directing claimant's counsel to distribute the remaining balance of settlement proceeds to LUA, we further stated that our order would become final unless it was appealed within 30 days. Inasmuch as claimant has timely petitioned for judicial review of our order, the directive to claimant's counsel which is contained in our decision is neither final nor effective.

In support of her contention, claimant relies on several court and Board decisions which hold that the lien of a paying agency attaches to a workers' compensation beneficiary's share of an estate's third party recovery. See generally Scarino v. SAIF, 91 Or App 350, 353-54 (1988). She also refers to a Board order which dismissed a carrier's petition for third party relief where the probate court had previously ruled that the carrier's lien did not attach until distribution of proceeds to a workers' compensation beneficiary. See James W. Swanson, 40 Van Natta 780 (1988).

Although each of the decisions cited in claimant's motion pertain to the general issue of lien attachment to wrongful death proceeds, we do not consider any of these holdings to be controlling. To begin, unlike the present case, none of the cases involved separate recoveries from separate third parties. Rather, each decision pertained to the distribution of proceeds from one distinct recovery. Thus, prior to our distribution order, there was no case precedent regarding whether litigation expenses incurred during the prosecution of one third party recovery may be offset against proceeds from a separate third party recovery.

In other words, the aforementioned holdings support the proposition that a paying agency's lien does not attach to a third party recovery prior to distribution of estate proceeds to a workers' compensation beneficiary. However, those holdings do not address the question of whether such distributions to beneficiaries must be made separately for each distinct settlement or judgment or whether those distributions may be made following the commingling of costs from each cause of action. The latter question is the issue which the parties presented to us for resolution.

Claimant's argument presumes that the probate court will direct the estate to offset expenses incurred from the "Navistar" recovery against proceeds from the "D-9" settlement before distribution of proceeds to the estate's beneficiaries. That may well be true. Nevertheless, before doing so, it would likely behoove the probate court to consider the same countervailing arguments, as well as applicable points and authorities, as were discussed in our distribution order.

Our holding in Swanson does not support the proposition that we are somehow divested of authority by claimant's "ex post facto" petition to the probate court for distribution of the estate's proceeds. In Swanson, the probate court had previously addressed and resolved the identical distribution issue posed by the carrier. Inasmuch as the probate court had already ruled on the issue, we dismissed the petition. In doing so, we emphasized that we were "empowered to resolve third party disputes such as this." Swanson, supra, at page 782. Thus, our decision was not premised on the theory that we lacked authority to resolve the distribution issue regarding proceeds from a third party recovery. Rather, our holding was based on the fact that another forum had already entertained and decided the issue.

Here, in contrast to Swanson, our consideration of the parties' respective arguments and resolution of their distribution dispute preceded claimant's petition to the probate court. Claimant is certainly entitled to seek probate court action. Likewise, the court will address the petition (and presumably LUA's argument in opposition) in accordance with its statutory authority. In doing so, the probate court may well avail itself of some of the reasoning expressed in our prior decision. In any event, such subsequent events do not expunge or eliminate our statutory authority to resolve a dispute regarding a "just and proper" distribution of third party settlement proceeds which was properly before us. See ORS 656.593(3).

Finally, this case is presently pending before the court, where the parties can present their respective arguments regarding claimant's current "jurisdictional" issue, as well as the other questions addressed in our prior decision. In light of such circumstances, including the virtual certainty that this legal issue will ultimately be presented to the court whatever our decision would be, we decline to withdraw our prior order for reconsideration. We have previously reasoned that in such situations it is in the interests of judicial and administrative efficiency to expedite the ultimate resolution of a legal issue which may have profound implications on the workers' compensation system. See Carole A. Vanlanen, supra.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA ARMAS, Claimant
Own Motion No. 94-0238M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable right knee sprain injury. Claimant's aggravation rights expired on July 14, 1988. SAIF recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery, and therefore claimant is eligible for temporary disability compensation. However, in a letter dated May 9, 1994, claimant stated that "for now I am only requesting Medical Benefits." Apparently, claimant wishes to use vacation time for her surgery, and also stated that "[i]f I lose any time after June 1, 1994 I will contact [SAIF]."

Accordingly, we are unable to authorize temporary disability benefits at this time, as claimant is not requesting them. If claimant's circumstances change, she may request reopening via Reconsideration of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANITA G. RAGAN, Claimant
WCB Case No. 91-12219
ORDER ON REMAND (REMANDING)
Michael B. Dye, Claimant Attorney
Garrett, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to its April 19, 1994 order, the court has remanded for reconsideration of 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). Specifically, we have been directed to reconsider our decision in light of Soto v. SAIF, 123 Or App 358 (1993) and Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A January 17, 1991 Notice of Closure closed claimant's claim and awarded temporary disability only. Claimant requested reconsideration, objecting to the impairment findings used to close the claim.

An August 30, 1991 Order on Reconsideration affirmed the Determination Order in all respects without prior appointment of a medical arbiter. Claimant requested a hearing regarding the Order on Reconsideration, raising as issues unscheduled and scheduled permanent disability, premature claim closure, and temporary total disability.

The Referee set aside the Order on Reconsideration and dismissed claimant's request for hearing. Claimant requested Board review.

We affirmed the Referee's order. In so doing, we relied primarily on our decision in Olga I Soto, 44 Van Natta 278 (1992), recon den 44 Van Natta 1609 (1992). Thus, we implicitly agreed with the Referee that the Order on Reconsideration was invalid because it issued without consideration of a medical arbiter's report under ORS 656.268(7). Accordingly, we concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order.

In Pacheco-Gonzalez v. SAIF, supra, 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, supra at page 316; see Wickstrom v. Norpac Foods, Inc., 125 Or App 520 (1993) ("Post-reconsideration" medical arbiter's reports are admissible under former ORS 656.268(6)(a)); Soto v. SAIF, supra.

In this case, relying on its decisions in Pacheco-Gonzalez v. SAIF, supra, and Soto v. SAIF, supra, the court has remanded for reconsideration of our prior order. Accordingly, we proceed with our reconsideration.

All exhibits offered at hearing were admitted, including a medical arbiter's "post-reconsideration" report. Since the report is in the record, we are authorized to proceed with our review without remanding to the Referee. See generally, Russell H. Fowler, 46 Van Natta 746 (1994). However, in this case, no testimony was taken.

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 court's recent decision in Pacheco-Gonzalez v. SAIF, supra, we find a compelling reason to remand. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993). Consequently, we remand this matter to the Referee for further evidence taking. See Jimmy L. Holsapple, 46 Van Natta 67 (1994).

Accordingly, the Referee's order dated March 20, 1992 is vacated. We remand to Referee Garaventa to conduct further proceedings 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.

May 20, 1994 Cite as 46 Van Natta 990 (1994)

In the Matter of the Compensation of
SUSAN M. SANCHEZ, Claimant
WCB Case No. 93-04077
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Claimant requests reconsideration of our April 21, 1994 Order on Review, which reversed the Referee's order setting aside the SAIF Corporation's denial of claimant's occupational disease claim for right carpal tunnel syndrome. Claimant asserts that there is no substantial evidence to support our finding that her right carpal tunnel syndrome is not compensable.

In order to further consider claimant's contentions, we withdraw our April 21, 1994 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 92-06386
SECOND ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Claimant requests reconsideration of our March 3, 1994 Order on Reconsideration in which we: (1) concluded that we erred in our November 16, 1993 Order on Review by raising a "back-up" denial theory of compensability on our own motion; (2) found that claimant had not proved her degenerative lumbar spine condition compensable as either a "resultant" condition or as an occupational disease; and (3) reinstated and upheld the self-insured employer's April 1992 "resultant" condition denial of claimant's current lumbar spine condition. On March 31, 1994, we abated our March 3, 1994 Order on Reconsideration to further consider claimant's request and provide the employer an opportunity to respond to claimant's motion. Having received the employer's response and claimant's reply, we proceed with our reconsideration.

Citing ORS 656.295(6) and Destael v. Nicolai Co., 80 Or App 596, 600 (1986), claimant contends that, on de novo review, the Board has the authority to make any disposition of a case that it deems appropriate, including considering a theory of compensability not raised at hearing or on review. The employer, on the other hand, argues that claimant specifically waived her right to pursue a "back-up" denial theory of compensability at hearing and did not raise a "back-up" denial theory on Board review. Claimant replies that her reference to the lack of a "back-up" denial at hearing was taken out of context.

Inasmuch as we hold that the employer's April 1992 denial was an invalid pre-closure denial of an accepted condition, we conclude that we need not address the parties' arguments.

Subsequent to our order on reconsideration, the Court of Appeals issued United Airlines, Inc. v. Brown, 127 Or App 253 (1994), and Sheridan v. Johnson Creek Market, 127 Or App 259 (1994), in which it found that a carrier's pre-closure "resultant condition" denial under ORS 656.005(7)(a)(B) is not procedurally valid where the claim has not first been closed. Because we find Brown and Sheridan controlling, we replace our prior orders with the following order.[1]

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," 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 by checking the appropriate boxes 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 obtained 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 denial of claimant's degenerative lumbar spine condition as "preexisting and not relat[ed] to your [October 11, 1988] injury."

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[1] Our consideration of the validity of the employer's pre-closure denial in this order is distinguishable from our having raised a "back-up" denial theory of compensability on our own motion. Here, during the pendency of our review, the Court of Appeals ruled that ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim prior to claim closure. More importantly, whereas claimant waived her right to pursue a "back-up" denial theory of compensability at hearing, no party waived its right to challenge/defend the validity of the April 1992 denial itself. Therefore, notwithstanding our prior holding that we erred by raising a "back-up" denial theory of compensability on our own motion, in light of the Court of Appeals' recent pronouncement in United Airlines, Inc. v. Brown, supra, and Sheridan v. Johnson Creek Market, supra, we consider the validity of the employer's pre-closure denial on review.

Thereafter, on August 17, 1992, claimant's claim was closed by Determination Order.

CONCLUSIONS OF LAW AND OPINION

An insurer may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. United Airlines, Inc. v. Brown, supra (citing Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983)); Sheridan v. Johnson Creek Market, supra.

In United Airlines, Inc. v. Brown, supra, the court affirmed a Board order which held that a carrier's "resultant condition" denial under ORS 656.005(7)(a)(B) did not entitle the carrier to discontinue a claimant's temporary disability on an open claim. The carrier argued that because the claimant's preexisting degenerative disease was the major contributing cause of her disability, its denial was procedurally valid. The court disagreed, finding nothing in the text or context of ORS 656.005(7)(a)(B) to suggest that the legislature intended that provision to provide a carrier with the procedural authority to deny an accepted claim. Consequently, the court held that if a carrier concludes that the compensable injury is no longer the major contributing cause of the disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268.

Similarly, in Sheridan v. Johnson Creek Market, supra, the court reversed a Board order which had upheld a carrier's denial of a claimant's "resultant condition" as of a date prior to claim closure. Citing United Airlines v. Brown, supra, the court reiterated that ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Septra 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 a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988).

Here, we find that the employer accepted claimant's degenerative back condition. Specifically, on the 801 form, claimant complained of low back and abdominal 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 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.

Moreover, at the time the employer issued its "resultant" condition denial of claimant's accepted condition, the claim had not yet been closed. Therefore, the employer's April 17, 1992 denial was an invalid pre-closure denial of an accepted condition. Accordingly, it must be set aside. United Airlines, Inc. v. Brown, supra; Sheridan v. Johnson Creek Market, supra.

Temporary Disability

We adopt and affirm the Referee's conclusions and reasoning, with the following comment. Claimant's hearing request as it pertains to 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 counsel's services on review concerning the compensability issue is $1,200. 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.

Accordingly, on reconsideration, and in lieu of all prior orders, we issue the following order. The Referee's order dated November 25, 1992 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the self-insured employer. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 23, 1994 Cite as 46 Van Natta 993 (1994)

In the Matter of the Compensation of
JUAN M. ZURITA, Claimant
WCB Case No. 93-02939
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial of a claim for an ankle injury. The issue on review is whether the injury occurred within the course and scope of claimant's employment.

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

Claimant regularly played basketball on the employer's premises during his paid break. During one such game, he injured his ankle. To prevail on his claim for this injury, claimant must first establish that he was not playing basketball primarily for personal pleasure. ORS 656.005(7)(b)(B). He must then establish that his injury is compensable under the Mellis unitary work connection test. See Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985).

We agree with the Referee's conclusion that the claim is not compensable under ORS 656.005(7)(b)(B) because claimant was playing basketball primarily for his personal pleasure. See Michael W. Hardenbrook, 44 Van Natta 529 (1992), aff'd mem 117 Or App 543 (1992). Moreover, even if the claim was not excluded under that provision, it would not be compensable under the Mellis test.

The courts have identified several factors to be considered under the Mellis test, including: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission. No one factor is dispositive. See Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985).

Some of the circumstances surrounding the injury in this case do support a work connection. In particular, the employer installed a cement playing area in the warehouse and provided the basketball. However, participation in the basketball game was voluntary, and there is no evidence the employer encouraged claimant to play basketball. Compare Ester E. Edwards, 45 Van Natta 1065 (1992) (injury during volleyball game sponsored and organized by employer to improve communication between workers). Moreover, claimant testified that he played basketball because it was fun. (Tr. 11).

We recognize that claimant also testified that he felt a need to play basketball to improve his relationship with his supervisor. (Tr. 10). However, claimant frequently played basketball when his supervisor was not participating. Moreover, more than improvement in employee health or morale is required to constitute a benefit to the employer. See Richmond v. SAIF, 58 Or App 354 (1982); Troy D. Bjugan, 45 Van Natta 1172 (1993); Steven M. Chambers, 42 Van Natta 2600 (1990). Here, there is no evidence of any other benefit to the employer. On this record, we conclude that claimant's basketball injury was not sufficiently related to his work activity to be compensable under the unitary work connection test.

ORDER

The Referee's order dated June 7, 1993 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant's injury is barred under the statutory exclusion set forth at ORS 656.005(7)(b)(B).

Only the SAIF Corporation has an interest in proposing, pursuant to this statute, that claimant's injury occurred during recreational activities primarily for his personal pleasure. Accordingly, as the proponent of the asserted fact, SAIF has the burden to prove the truth of its assertion. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1980) (burden of proof lies with the party having the affirmative of any given issue); Roger D. Hart, 44 Van Natta 2189, 2191 (1992) (insurer has burden of establishing under ORS 656.273(1) that major cause of worsening is off-work injury); Rick D. Brady, 42 Van Natta 1611 (1990) (insurer has burden to demonstrate that claimant engaged in injurious practices within the meaning of ORS 656.156(1)).

Here, the employer initiated the basketball play by installing a cement playing area in its warehouse. It further facilitated and encouraged the activity by providing the basketball and allowing workers to play during paid breaks. The employer's actions in this regard convince me that it realized significant benefits from claimant's basketball play. In particular, claimant testified that he played basketball, in part, to improve his relationship with his supervisor. Moreover, it is generally recognized that this type of physical exercise promotes productivity by alleviating worker tension and stress.

Under these circumstances, SAIF has not carried its burden of proving that claimant's basketball play was engaged in primarily for personal pleasure. Accordingly, I would find that claimant's injury does not fall within the 1990 statutory exclusion set forth at ORS 656.005(7)(b)(B).

Having found no statutory bar to compensability, I would further conclude that the connection between the basketball game and claimant's work is sufficient to establish compensability under the Mellis unitary work connection test. Unlike the majority, I regard the benefit to the employer as more than a general improvement in employee health or morale. The employer enjoyed the particular benefit of improved working relationships and productivity. These were of more than incidental benefit to the employer.

For these reasons, I would reverse the Referee and set aside SAIF's denial of claimant's basketball injury. Accord Michael W. Hardenbrook, 44 Van Natta 529 (1992) (Board Member Moller's dissent). Therefore, I respectfully dissent.

In the Matter of the Compensation of
ERASMO N. AGUILAR, Claimant
WCB Case No. 92-16019
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee T. Lavere Johnson's order that declined to grant permanent total disability and increased his award of unscheduled permanent disability from 11 percent (35.2 degrees), as awarded by an Order on Reconsideration, to 13 percent (41.60 degrees). In his brief, claimant contends that the increase in unscheduled permanent disability should be greater. On review, the issues are permanent total disability and, if claimant is found not to be permanently totally disabled, the extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

A May 7, 1992 (not 1991) Determination Order closed claimant's claim.

Claimant's duties as a Landscape Laborer (DOT 408.687-014) included planting trees and flowers, mowing lawns, pruning trees, washing patios, cleaning up gardens, changing irrigation pipe, and making rock designs in patios. He worked as a member of a crew of four and performed as crew leader when the boss was not there. This job is classified as heavy, with an SVP of 2.

Claimant's job at the time of injury was a Choker Setter (DOT 921.687-014), which is classified as very heavy work, with an SVP of 2.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt and affirm the Referee's opinion on this issue.

Disability Rating - Applicable Standards

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994). Claimant's claim was closed by a May 7, 1992 Determination Order. Consequently, the standards effective March 13, 1992, as set forth in WCD Admin. Order 6-1992, apply.

Disability Rating

Claimant requests an increase in unscheduled permanent disability. He specifically raises the issue of the value attributed to skills, which, under the standards applied by the Referee, were not only a component of the education value, but also aided in establishing the adaptability value. See former OAR 436-35-300 and 436-35-310 (WCD Admin. Order 93-052). Under the standards we apply here, the skills value is a component of the education factor, and the adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity (RFC) at the time of determination. See former OAR 656-35-300 and OAR 436-35-310(1) (WCD Admin. Order 6-1992). Consequently, we address both the value for skills and the value for adaptability.

A value for a worker's skills is allowed based on the highest specific vocational preparation (SVP) time in a job the worker has performed during the ten years preceding the time of determination. Former OAR 436-35-300(4). The Referee concluded that the duties of a Landscape Supervisor (DOT 406.134-014) most accurately reflected the job claimant held that established his highest SVP. We disagree.

Claimant's duties included the following: Planting trees, flowers, mowing lawns, pruning trees, washing patios, cleaning up gardens, changing irrigation pipe, and making rock designs in patios. He worked as a member of a crew of four and "supervised" the crew when the boss was not there. There is no evidence that he performed actual supervisory duties, such as supervising and coordinating activities of the workers, developing and assigning duties to accomplish production schedules, and performing other planning, supervisory or coordinating activities. Rather, his duties were that of a lead person expediting the work of a small crew when the boss was not there and explaining tasks to new workers. Any "supervisory" functions were incidental to the duties he performed as a member of the crew. See Dictionary of Occupational Titles, Vol. 1, 4th Ed., 1991. Cf. Master Title "Supervisor," pg. 2, with "Straw-boss," pg. 9. See also Landscape Supervisor (museums, waterworks) (DOT 406.134-014) (includes supervision and coordination of maintenance workers in parks, botanical gardens and playgrounds, planning landscaping tasks, instructing workers, and performing other duties described under "Supervisor" Master Title).

Claimant contends that Yard Worker (DOT 301.687-018) most accurately reflects the duties he performed. Because claimant's prior experience was six months as a Landscape Laborer (DOT 408.687-014), and because he was considered experienced enough to be the lead on a landscaping crew that serviced homes in a country club environment, we conclude that the job of Landscape Laborer most accurately reflects claimant's duties. See former OAR 436-35-300(4)(a). Claimant met the SVP for this occupation after remaining in the field long enough to meet the training/skill requirements of that occupation through on-the-job training. See former OAR 436-35-300(4)(c). The SVP for this job is 2, which establishes a value of 4. Former OAR 436-35-300(4)(e). In addition, although claimant contends that he has a certificate as a Welding Technician, it was conferred by a school in Mexico sometime in the 1980's. There is no evidence that it is a current license or certificate of completion necessary for employment in an Oregon job. Furthermore, claimant has not achieved an SVP of 5 or higher. Accordingly, an additional value of 1 is allowed. Former OAR 436-35-300(5). Thus, the total for claimant's formal education (0), and skills (5) is 5. Former OAR 436-35-300(6).

Claimant's job at the time of injury was a Choker Setter (DOT 921.687-014), which is very heavy work. His treating physician, Dr. Bush, released him to work with a lifting restriction of 25 pounds, which is between light and medium. Accordingly, his RFC is medium/light. A comparison between the strength demands of his job at the time of injury and his RFC is a value of 4. Former OAR 436-35-310(3).

We proceed to assemble the factors comprising unscheduled disability. Neither party contests the values assigned to impairment (5) and age (0). The values for age (0) and education (5) are added for a value of 5. Former OAR 436-35-280(4). The value for adaptability is 4. Former OAR 436-35-310(3). The adaptability value (4) is multiplied by the education value (5) for a value of 20. Former OAR 436-35-280(6). This value (20) is added to the impairment value (5) for a total of 25 percent unscheduled permanent disability to be awarded. Former OAR 436-35-280(7).

ORDER

The Referee's order dated September 14, 1993 is affirmed in part and modified in part. In addition to the Referee's Order on Reconsideration awards of 13 percent (41.6 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees), for a total award to date of 25 percent (80 degrees) unscheduled permanent disability. Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, provided the total of fees approved by the Referee and the Board does not exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN Q. EMMERT, Claimant
WCB Case Nos. 91-14932 & 91-07717
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Mongrain's order which upheld the SAIF Corporation's denials of claimant's current coronary disease, arrhythmia condition and hypertension. On review, the issue is compensability.

We adopt and affirm the Referee's order. We provide the following supplementation to address claimant's arguments on review.

First, claimant contends that SAIF's 1981 acceptance encompassed both a myocardial infarction (MI) and coronary artery disease (CAD). We disagree.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). However, where a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988). When the acceptance does not identify the specific condition, we look to contemporaneous medical records to determine what condition was accepted. Cecilia A. Wahl, 44 Van Natta 25050 (1992).

Here, SAIF's notice of acceptance did not identify any particular condition. (Ex. 20). Instead, it accepted a disabling injury occurring on March 24, 1981, described only as "999 430." (Id). The code designations mean "unclassified" (999) and "chest, including ribs, breast bone, and internal organs of the chest" (430). (Ex. 71 at 3-5). Accordingly, we turn to contemporaneous medical records.

Here, the "801" claim form described "severe chest pains." (Ex. 3). The next day claimant was admitted to the hospital where he was diagnosed as having an acute myocardial infarction. (Exs. 4, 5, 13).

Claimant relies on the June 1981 report of consulting cardiologist Dr. Schaeffer to establish that SAIF accepted both an MI and the underlying CAD. (See Ex. 18). Dr. Schaeffer described claimant's then-current condition as "coronary artery disease status post-acute anteroseptal myocardial infarction." (Ex. 18-1). He also explained that claimant's acute MI was caused, in material part, by work-related stress superimposed on his "obviously preexisting coronary artery disease." (Ex. 18-2). Two weeks after Dr. Schaeffer's report, SAIF accepted the claim. (Ex. 20).

In light of the contemporaneous and specific diagnosis of myocardial infarction, we do not find that Dr. Schaeffer's later report explaining the interrelationship between CAD and the acute MI establishes that SAIF accepted both the MI and underlying CAD. Accordingly, we conclude that SAIF did not accept claimant's coronary artery disease in 1981.

Claimant also contends that SAIF accepted the symptoms of an MI and CAD. Relying on Georgia-Pacific v. Piwowar, 305 Or 494 (1988), he contends that these are inseparable conditions which cannot now be separated and denied. We reject this argument because we find no competent medical evidence to support claimant's theory. See Howard L. Chant, 45 Van Natta 8, 10 (1993). Therefore, Piwowar, supra, does not apply in this case.

Second, claimant argues that in order to prove compensability of his current coronary condition, he need only establish that his 1981 myocardial infarction was a material, not the major, contributing cause of his current condition.

If a work incident directly causes a condition, the material contributing cause standard applies. However, when it is alleged that the compensable condition in turn caused another condition, the appropriate standard is major contributing cause. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Here, the medical evidence does not establish that the industrial accident directly caused claimant's current condition. Rather, the medical evidence establishes a causal relationship between claimant's compensable MI and his current condition. Therefore, the applicable standard is major contributing cause. See ORS 656.005(7)(a)(A).

After our review of the record, we find that the medical evidence, at best, establishes only a material causal relationship between the 1981 MI and claimant's current condition. (See Exs. 56, 56A, 59A, 60, 66A). Accordingly, we agree with the Referee that claimant failed to establish a compensable relationship between the MI and his current coronary condition.

Finally, claimant contends that his current condition is compensable under ORS 656.802(4), based on the "fire fighter's presumption."[1] However, in order to take advantage of the presumption, claimant must have undergone a "competent and rigid" examination that would have revealed any preexisting coronary disease. SAIF v. Bales, 107 Or App 198, on rem 43 Van Natta 1866 (1991); Robert Winkel, 45 Van Natta 991 (1993).

SAIF contends, and the Referee found, that the required physical examination was not performed. We agree. Claimant had a physical examination prior to undergoing surgery in 1978. (Ex. A). The examination revealed a normal heart and blood pressure. However, the operating physician explained that his examination did not rule out CAD, and that it was quite possible that claimant had severe CAD at that time. (Ex. 70). Under such circumstances, we agree with the Referee that the 1978 physical examination was not an adequate physical examination under ORS 656.802(4) to trigger the "fire fighter's presumption." See Robert Winkel, supra. Furthermore, we agree with the Referee that without the presumption, claimant has not proved a compensable occupational disease.

Accordingly, we affirm the Referee's order upholding SAIF's denial of claimant's current CAD, hypertension and arrhythmia condition.

ORDER

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

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[1] ORS 656.802(4) provides, in relevant part:

"Death, disability or impairment of health of fire fighters . . . caused by . . . hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a fire fighter's employment. However, any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the fire fighter's employment."

Board Member Gunn dissenting.

Because I believe the SAIF Corporation accepted not only claimant's 1981 myocardial infarction (MI), but also his underlying coronary artery disease (CAD), I would conclude that claimant's CAD is part of his accepted claim. Therefore, I respectfully dissent.

After my review of the record, I conclude that the medical evidence establishes that claimant's 1981 MI was not a separate condition from his underlying CAD, but was merely a symptom of the underlying coronary disease. (See Ex. 18). By accepting a symptom of the disease, SAIF also accepted the disease that caused the symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988). Therefore, I conclude that by accepting the MI, SAIF also accepted the underlying heart disease. Accordingly, I would hold that SAIF's "current condition" denial should be set aside as an improper "back-up" denial of the previously accepted coronary artery disease. See Bauman v. SAIF, 295 Or 788, 793-94 (1983).

In the Matter of the Compensation of
WILLIAM F. GILMORE, Claimant
WCB Case Nos. 91-04989 & 91-04663
ORDER ON REMAND
Burt, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). The Supreme Court has reversed the Court of Appeals decision, 123 Or App 122 (1993), which had affirmed our prior order, William F. Gilmore, 45 Van Natta 410 (1993), that held that claimant's knee injury was compensable because it occurred in the employer's parking lot. Reasoning that we neglected to examine the causal connection between claimant's employment and his injury to determine if he had shown a sufficient work-connection to establish compensability of his claim, the Supreme Court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the findings of fact contained in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

On March 4, 1991, claimant worked a full shift as a quality control grader at the employer's place of business. At the end of his shift, claimant left the plant and walked to his car, which was parked in a lot owned and maintained by the employer. When claimant got to his car, he opened the door and began to enter the vehicle. As claimant was sliding into the driver's seat, he felt his right knee "grab/lock up," which produced excruciating pain. He backed out of his car and kicked his right leg out straight, which produced a popping sound, along with swelling and extreme pain in his right knee. Claimant drove home. At the time claimant was injured, he had completed all work duties, and he was not compensated by the employer for the time between completion of his duties and his arrival home.

The next day, claimant went to the emergency room of a local hospital for his right knee complaints. The attending physician took claimant off work and advised him to visit an orthopedic surgeon. Claimant subsequently received treatment, including arthroscopy. The treatment was successful, and claimant returned to work in April 1991.

When the employer denied claimant's injury claim, claimant requested a hearing. Finding that claimant had not established a causal work connection between the parking lot incident and his knee condition, the Referee upheld the employer's denial. Claimant requested Board review.

We reversed the Referee's order. Relying on Boyd v. SAIF, 115 Or App 241, 244 (1992), we reasoned that "[t]he fact that the injury occurs on employer-controlled premises while the employee is traveling to and from work makes the incident sufficiently work connected" to establish compensability of the injury.

The employer petitioned for judicial review of our order. The Court of Appeals affirmed our decision without opinion. Norpac Foods, Inc. v. Gilmore, 123 Or App 122 (1993). The Supreme Court has reversed the Court of Appeals decision and our order. 318 Or 363 (1994). Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the Court explained that there are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment.

Clarifying its decision in Cope v. West American Ins Co., 309 Or 232 (1990), the Supreme Court further explained that application of the "parking lot rule" establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element, but that the second element of the work-connection inquiry must also be satisfied. Thus, to prove compensability, claimant must also establish that his injury "arose out of" his employment.

The Supreme Court has remanded the case to the Board with instructions to examine the record to determine whether there was a sufficient causal connection between claimant's employment and the injury to satisfy the second element of the test. In accordance with the Court's mandate, we proceed with our reconsideration.

Applying the "unitary work connection" analysis, the Referee found no evidence of any condition associated with the employer's parking lot that brought about the "knee-locking" episode. The Referee, therefore, concluded there was an insufficient relationship between the March 4 "knee-locking" episode and claimant's employment to justify compensability. We agree.

The employer's parking lot did not expose claimant to any risks different from those encountered by any person getting into his car. See Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991) (the "increased danger" of injury attributable to driving a vehicle for the employer's benefit); Emery A. Reber, 43 Van Natta 2373 (1991) (substantial employment contribution where the claimant fell from second story height, received direct hit on the top of his head and rendered him a quadriplegic). Claimant had completed his work for the day and was on his way home. He was not paid during the time in which the injury occurred. Other than the mere fact that claimant's injury occurred on the employer's premises, we find no other "risk" connected with his employment. Thus, claimant's injury did not result from an act which was an ordinary risk of, or incidental to, his employment and, therefore, did not "arise out of" his employment. Consequently, we conclude that claimant has failed to establish a sufficient causal connection between his employment and the injury to justify compensability.

In the alternative, claimant contends that his right knee condition is compensable as an aggravation of his accepted July 1987 right knee claim for torn lateral meniscus. To establish an aggravation, claimant must prove a worsening of his compensable condition since the last award or arrangement of compensation. The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1). 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. Id.

Dr. Gallagher, claimant's treating physician for the March 1991 injury, reported that he found no objective medical evidence that claimant's 1987 meniscus tear had worsened. When Dr. Gallagher performed surgery, he found no new tears of the lateral meniscus. Dr. Gallagher opined that the March 4, 1991 incident represented either catching of a congenital hypermobile discoid lateral meniscus or subluxation of the patella, but in either case, it was a new injury. (Exs. 22, 26).

In a check-the-box response, Dr. Poulson, claimant's treating physician for the July 1987 injury, opined that the 1987 injury remained the major contributing cause of claimant's current right knee condition. (Ex. 27). We find Dr. Poulson's unexplained, conclusory opinion regarding causation is unpersuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Poulson's opinion is also insufficient to establish that claimant's compensable condition has worsened.

Based on Dr. Gallagher's opinion, we find that claimant has failed to establish that his compensable 1987 right knee condition has worsened. Moreover, as discussed above, the March 1991 injury did not occur within the course and scope of employment. Thus, claimant has also failed to establish a causal connection between his compensable condition and his current right knee condition. Consequently, claimant has failed to prove a compensable aggravation claim.

Accordingly, on reconsideration, we affirm the Referee's order dated April 17, 1992.

IT IS SO ORDERED.

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case Nos. 92-11012 & 92-10411
SECOND ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

On March 28, 1994, we issued an Order on Reconsideration which increased claimant's carrier-paid attorney fee award for her counsel's efforts in obtaining a pre-hearing rescission of the SAIF Corporation's "de facto" denial of an adhesive capsulitis condition from $150, as granted by our February 4, 1994 Order on Review, to $500. In reaching such a conclusion, we noted that we had not received a timely response from SAIF concerning claimant's motion for reconsideration.

Following issuance of our reconsideration order, SAIF's response (which was hand-delivered to our Salem office on March 18, 1994) was brought to our attention. Although received in timely compliance with the schedule implemented in our March 4, 1994 Order of Abatement, SAIF's response was initially misdirected to another Board file.

In light of such circumstances, we treated SAIF's response as a motion for reconsideration of our March 28, 1994 Order on Reconsideration. In order to further consider this matter, we withdrew our prior orders and granted claimant an opportunity to respond. Having now considered claimant's timely response, we proceed with our reconsideration.

On reconsideration, SAIF objects to an increased attorney fee, as it argues that, with the exception of a letter amending claimant's request for hearing and adding the additional issue of the adhesive capsulitis condition, there is no evidence of the amount of attorney time devoted to the issue. SAIF also argues that the value to claimant is minimal as SAIF's medical examiner found the claim to be work-related, SAIF never contested the issue, and, additionally, SAIF paid all benefits on the claim. Finally, SAIF argues that the majority of issues were withdrawn by claimant at hearing, including the extent of disability issue, which arguably was the only issue which might have resulted in any benefit to claimant.

Claimant has not provided any response to SAIF's brief filed on reconsideration. Rather, claimant has merely resubmitted her original request for reconsideration which contends that a fee of $150 is inadequate.

After reviewing both claimant's and SAIF's responses, and considering the factors set forth in OAR 438-15-010(4), we conclude that our initial order appropriately awarded an assessed attorney fee in the amount of $150. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

Accordingly, as supplemented herein, we republish our February 4, 1994 Order on Review in its entirety, 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
TIVIS E. HAY, Claimant
WCB Case Nos. 92-13904, 92-11494 & 92-09270
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Livesley's order that: (1) set aside its denial of claimant's occupational disease claim for a low back condition; and (2) upheld the responsibility portion of the SAIF Corporation's denial of the same condition. In its respondent's brief, SAIF contests that portion of the Referee's order that set aside the compensability portion of its denial. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant worked for the same employer between 1976 and 1992. SAIF was on the risk from at least 1984 through December 31, 1990. Thereafter, Liberty was on the risk.

Claimant first sought treatment for his current low back condition in January 1992, when he consulted Dr. Gurney, his treating physician, with complaints of increasing back pain. After SAIF and Liberty denied claimant's current low back condition,[1] he was examined by Drs. Englander and Woolpert on Liberty's behalf.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusion regarding the compensability of claimant's occupational disease claim for his current low back condition.

Responsibility

Claimant sustained a compensable low back injury in 1984, while SAIF was on the risk. The claim was closed in May 1984. In 1986, claimant sought further medical treatment for low back symptoms, which treatment was apparently paid by SAIF. Claimant's onset of additional symptoms occurred shortly after his job duties were changed to include extensive time driving on logging roads. In 1987, claimant was examined by Dr. Schachner on SAIF's behalf. Dr. Schachner noted lumbosacral degenerative disc disease on claimant's spinal x-ray.

In June 1991, while Liberty was on the risk, claimant compensably injured his left leg and right shoulder. Liberty accepted a claim for contusion/abrasion left leg/right shoulder.

Thereafter, claimant began to experience low back pain. In January 1992, claimant consulted his treating physician, Dr. Gurney, who obtained an MRI that revealed extensive degenerative changes at L5-S1. (Ex. 9). Both SAIF and Liberty denied responsibility for claimant's current low back condition. Claimant requested a hearing. The Referee concluded that, under the last injurious exposure rule, Liberty was the responsible insurer.

Liberty argues that, because SAIF accepted the same condition as that for which claimant presently seeks compensation, SAIF is the responsible insurer. We disagree.

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[1] SAIF and Liberty denied both the compensability of and responsibility for claimant's current condition. (Exs. 12, 13, 17). At hearing, both insurers amended their denials to include a denial of claimant's condition as an occupational disease. (Tr. 1).

We have agreed with the Referee's conclusion that claimant's current low back condition was caused by work conditions that existed while both SAIF and Liberty were on the risk. Since we have found the condition compensable, the question remains which carrier is responsible. Therefore, our first inquiry is whether this case is governed by ORS 656.308(1). To answer that question, we must determine if the condition for which claimant currently seeks compensation is the "same condition" as the condition that SAIF accepted in 1984. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993).

In 1984, SAIF accepted claimant's "low back" injury claim without qualification. (Exs. 1, 3).[2] Inasmuch as claimant's current condition involves his low back, we conclude that his current condition is the "same condition" as that which SAIF accepted in 1984. See Smurfit Newsprint, supra.

The medical evidence supports this conclusion. Claimant's 1984 spinal x-rays revealed moderate degenerative changes at L5-S1. (See Ex. 20-13). His 1991 spinal MRI revealed extensive degenerative changes at L5-S1. (Ex. 9). Drs. Gurney, Englander and Woolpert have diagnosed claimant's current low back condition as degenerative lumbar disc disease at L5-S1. (See Exs. 8, 10A-3, 14A, 19-4). For this additional reason, we conclude that claimant's current condition is the "same condition" his 1984 low back condition. Accordingly, ORS 656.308(1) applies.

Claimant litigated this claim as a new occupational disease claim.[3] ORS 656.308 encompasses occupational diseases. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993). To establish a "new occupational disease" following the closure of an accepted claim, the carrier with the accepted claim has the burden of establishing that the claimant's work activities subsequent to the claim closure were the major contributing cause of the claimant's current condition. See ORS 656.802(2); Steven K. Bailey, 45 Van Natta 2114, 2116 (1993); see also SAIF v. Drews, 318 Or 1 (1993); Peggy Holmes, 45 Van Natta 278 (1993).

As the insurer with the accepted 1984 claim, SAIF has the burden of proof. See Steven K. Bailey, supra. Accordingly, to establish that claimant sustained a "new occupational disease" after the closure of claimant's 1984 injury claim, SAIF must prove that claimant's work activities following the closure of that claim were the major contributing cause of claimant's current low back condition. See Steven K. Bailey, supra; see also Peggy Holmes, supra. We conclude that SAIF has met that burden of proof.

Three physicians addressed the cause of claimant's current low back condition. Dr. Englander, who examined claimant on Liberty's behalf, noted that claimant could not say that the 1991 accident with Liberty had affected his low back. (Ex. 10A-1). That factor, coupled with claimant's history and 1987 spinal x-ray and 1992 MRI report, led Dr. Englander to conclude that claimant likely had a preexisting, progressive degenerative spinal condition, and that claimant's current low back condition was caused, in major part, by events that occurred before 1991. (See id. at 3-4).

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[2] Claimant's 1984 "801" form indicated that his "low back" was the body part affected by his February 27, 1984 work-related injury. (Ex. 1). By notice of acceptance, SAIF accepted that claim as "999 120." (Ex. 3). Because the record does not define the term "999 120", we conclude that SAIF's acceptance included any condition that involved claimant's low back. See Georgia-Pacific Corp. v. Piwowar, 305 Or 494 (1988) (when a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom).

The only evidence regarding the meaning of "999 120" is contained in SAIF's May 15, 1992 denial of claimant's current back condition. In the denial, SAIF stated that claimant's 1984 claimant "was accepted for low back strain and benefits provided according to law." (Ex. 12; emphasis added). (In its subsequent denial, SAIF said only that claimant had "filed a claim for an alleged injury to [his] low back * * *." (Ex. 13).) Even assuming the accuracy of SAIF's May 15, 1992 denial, in light of SAIF's general acceptance of claimant's "low back" injury claim and SAIF's subsequent denial, we do not consider SAIF's 1992 denial probative of what it accepted in 1984. See SAIF v. Tull, 113 Or App 449 (1992) (whether acceptance occurs is an issue of fact).

[3] Claimant also litigated this claim as an injury claim on the basis of his June 1991 work-related accident. We agree with the Referee's reasoning and conclusion that here was no persuasive medical evidence that causally linked that accident with claimant's current need for low back treatment.

Similarly, Dr. Woolpert, who examined claimant in February 1993 on Liberty's behalf, reported that claimant did not think that he was any different then than he had been before the June 1991 accident. (Ex. 19-3). After considering a sketchy history of claimant's work activities, his medical history and physical examination and 1984 and 1987 spinal x-rays, Dr. Woolpert concluded that claimant had degenerative disc disease at L5-S1 that had preexisted his 1984 work injury, and that the 1991 injury did not produce any worsening of that condition. (Id. at 4; Ex. 20-13). Dr. Woolpert also concluded that, in light of claimant's report that his condition had not worsened while Liberty was on the risk, claimant's occupational exposure during that time was not the major contributing cause of claimant's current back condition. (Ex. 19-4).[4]

In a March 1992 report directed to SAIF, Dr. Gurney, claimant's treating physician, recognized that claimant had degenerative disc disease. (Ex. 10). However, because claimant's back had been asymptomatic immediately before the June 1991 accident, Dr. Gurney concluded that the accident and the degenerative disc disease probably contributed to claimant's current low back condition, although he was unable say in what percentage. (Id.) At the time, he was unable to quantify to what extent claimant's 1984 accident contributed to his current low back condition. (Id.)

In an April 1992 report, again directed to SAIF, Dr. Gurney stated that claimant's June 1991 accident was "probably the thing that caused most of his symptoms that he is now having", and that his 1984 work accident was "probably less than 50% responsible for his current back problem." (Ex. 11).

In a September 1992 chart note, Dr. Gurney subsequently concluded that claimant's 1984 and 1991 work accidents, as well as "his being jossled [sic] around in a pickup truck during work related activities" cumulatively were the "overwhelming cause" of claimant's current condition, as compared to the mild degenerative changes in his lower back. (Ex. 14A). After considering Dr. Schachner's 1987 medical report, and additional details regarding claimant's history, Dr. Gurney reaffirmed his belief that claimant's cumulative work exposure at the employer was the major contributing cause of his current low back condition. (Ex. 15). In a supplemental concurrence letter drafted by SAIF's counsel, Dr. Gurney agreed that claimant's June 1991 accident, while Liberty was on the risk, was a material cause of claimant's current need for treatment. (Ex. 16).

When the medical evidence is divided, we tend to give greater weight to the reports of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

We find persuasive reasons to discount the opinions of both Drs. Englander and Woolpert. Dr. Englander's report was rendered without the benefit of claimant's 1984 spinal x-rays. As such, Dr. Englander's opinion that claimant's degenerative spinal condition likely preexisted his 1984 work injury is speculative.

Dr. Woolpert's opinion suffers from similar defects. During deposition, he admitted that it was possible that claimant's 1984 work injury caused some degenerative changes in claimant's lower spine. (See Ex. 20-18, -19). Moreover, Dr. Woolpert admitted that claimant's work exposure, including the jostling around while riding in a pickup truck, had an effect on claimant's current low back condition. (Id. at 27). Finally, Dr. Woolpert admitted that claimant's spinal condition was more deteriorated than one would expect from a man claimant's age. (See id).

For these reasons, we give minimal probative weight to the opinions of Drs. Englander and Woolpert.

In contrast, we find no persuasive reasons not to rely on the opinions of Dr. Gurney, claimant's treating physician. Dr. Gurney originally determined that claimant's degenerative disc disease and his 1991 work accident were contributing causes of his current low back condition. (Ex. 10). Dr. Gurney

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[4] In his medical report, Dr. Woolpert stated that claimant "also did not indicate worsening while he was employed at the company during the time Liberty Northwest was insuring the individual. Therefore, I do not think that there is a major contributing cause of the patient's condition to his work activity on an occupational basis other than the injury, which in my understanding is 1/1/91." (Ex. 19-4) In his deposition, Dr. Woolpert corrected the date to June 7, 1991 and clarified that his opinion did not mean that the June 7, 1991 accident was the major contributing cause of claimant's current condition. (Ex. 20-45).

ultimately concluded that: (1) claimant's entire work exposure, including his history of being jostled around in a pickup at work, was the major contributing or "overwhelming" cause of his current low back condition, as compared to the mild degenerative changes in his lower back; and (2) that claimant's degenerative spinal condition probably contributed to his current symptoms, but that those symptoms exceeded those that one would anticipate under normal circumstances for a man claimant's age. (Exs. 14A, 15-1). In the interim, Dr. Gurney issued two reports that concluded that claimant's June 1991 accident played a material, if not the major, role in claimant's current condition (see Exs. 11, 16), and that claimant's 1984 work accident was no more than a material cause of his current back problem. (See Ex. 11).

We interpret Dr. Gurney's reports to rank the 1991 accident and claimant's work activities as the most significant causes of claimant's current low back condition, and the degenerative disc disease and the 1984 accident as only minor causes of that condition. Because the record reveals that, sometime in 1986, claimant's job duties were changed to include extensive time driving on logging roads, we conclude that, read as whole, Dr. Gurney's reports establish that claimant's work exposure following the closure of his 1984 injury claim in May 1984 was the major contributing cause of his current low back condition.[5]

Based on the foregoing reasoning, we conclude that SAIF has established that a "new occupational disease" arose after the closure of claimant's 1984 injury claim. Accordingly, SAIF is not responsible for that condition under its 1984 accepted claim for claimant's original back injury. See ORS 656.308(1); Steven K. Bailey, supra. Because no carrier has accepted the "new" occupational disease claim for claimant's low back condition, it remains for us to determine who is responsible for that condition as between SAIF, as the carrier on the risk for claimant's work exposure between 1984 and 1991, and Liberty, as the carrier on the risk thereafter. To resolve that question, we apply the last injurious exposure rule, which governs the initial assignment of responsibility for conditions that have not been previously accepted. See Steven K. Bailey, supra, 45 Van Natta at 2117.

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 was on the risk, the last employment providing potentially causation conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Steven K. Bailey, supra. The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date on which the claimant first became disabled as a result of the compensable condition, or if the claimant did not become disabled, the date on which he or she first sought medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986).

The evidence establishes that claimant's employment while both SAIF and Liberty were on the risk contributed to claimant's current low back condition. The evidence further establishes that claimant first sought treatment for his current low back condition in January 1992, while Liberty was on the risk. (Exs. 8, 9). Accordingly, we find the "onset of disability" of claimant's current low back condition was in January 1992, at which time Liberty was on the risk.[6]

Consequently, responsibility for claimant's occupational disease is initially assigned to Liberty. 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 current low back condition, or that it was impossible for conditions while Liberty was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

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[5] Our conclusion regarding Dr. Gurney's reports finds support in the fact that none of the three physicians that rendered opinions regarding causation gave any particular weight to claimant's 1984 accident in ascertaining the cause of claimant's current low back condition. (See Exs. 10, 10A-4, 15, 16, 19-4).

[6] Even if claimant's "onset of disability" had occurred while SAIF was on the risk, we would still find Liberty responsible, because the evidence establishes that claimant's work exposure during Liberty's coverage actually contributed to his current low back condition. (See Exs. 14A, 15, 16). See Bracke v. Baza'r, supra; Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795, rev den 300 Or 162 (1985).

Dr. Gurney opined that claimant's cumulative work exposure (a period that spanned both SAIF's and Liberty's coverages) was the major contributing cause of claimant's current condition. (Exs. 14A, 16). Furthermore, although Liberty's examining physicians, Drs. Englander and Woolpert, concluded that claimant's work exposure while Liberty was on the risk was not the major cause of claimant's condition, a careful reading of their opinions reveals that they focussed almost entirely on the effect on claimant's current low back condition of his 1991 work injury, and not his 1991 work exposure. (See Exs. 10A, 19). Although Liberty had been on the risk a little over a year by the time claimant first sought medical treatment for his current low back condition, the evidence does not establish that SAIF's exposure was the sole cause of that condition or that it was impossible that claimant's work activities during Liberty's coverage could have caused the condition. See FMC Corp. v. Liberty Mutual Ins. Co., supra. Accordingly, on this record, we conclude that Liberty has not established its entitlement to shift responsibility to SAIF. Therefore, responsibility for claimant's current low back condition remains with Liberty.

In closing, we note that the Referee's order set aside the compensability portion of SAIF's denial. Because we have concluded that Liberty, and not SAIF, is responsible for claimant's current low back condition, we conclude that SAIF's entire denial should be upheld. Accordingly, we reverse that portion of the Referee's order and reinstate SAIF's denial in its entirety.

Claimant is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's services on review is $1,000, 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 May 27, 1993 is affirmed in part and reversed in part. The SAIF Corporation's denial is reinstated and upheld in its entirety. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
DARYL J. JOHNSON, Claimant
WCB Case Nos. 92-00613 & 91-18214
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Ron Pomeroy (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Brown's order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's aggravation claim for a psychological condition; and (2) upheld the SAIF Corporation's denial of her occupational disease claim for the same condition. On review, the issues are compensability (aggravation) and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings" numbered one through eleven, with the following supplementation.

On August 8, 1991, Liberty accepted claimant's claim for an "Anxiety Stress Reaction." This claim was closed by Determination Order on September 27, 1991, with no award of permanent disability.

Some time after October 9, 1991, claimant filed claims for work-related mental stress against Liberty and SAIF. Liberty and SAIF denied compensability and responsibility for claimant's psychological condition.

Claimant's current psychological problems are at least materially related to the condition which Liberty accepted. Claimant's work activities while SAIF was on the risk were not the major contributing cause of a worsening of her psychological condition.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note claimant's request for admission of proposed Exhibit 17, a March 10, 1992 letter from claimant's counsel to Dr. Gilmour, treating physician, including Dr. Gilmour's concurrence. Claimant avers that this document was inadvertently omitted from the master exhibit list at hearing and submits the letter on review. Neither Liberty nor SAIF objects to its admission. Under these circumstances, we treat the March 10, 1992 letter as part of the record, consider it on review, and refer to it as "original Exhibit 17." See Nellie M. Ledbetter, 43 Van Natta 570 (1991).

Compensability (Aggravation)

The Referee found that claimant's current psychological condition is not compensable because it resulted from a reasonable job performance evaluation in the course of claimant's work as a teacher's aide. See ORS 656.802(3)(b). We disagree, based on the following reasoning.

We note at the outset that claimant has an accepted claim with Liberty for a condition diagnosed as "Anxiety Stress Reaction." (Ex. 9). This claim was closed on September 27, 1991, with no award of permanent disability. (Ex. 12). In the fall of 1991, during SAIF's coverage (following an unfavorable performance evaluation), claimant experienced the same constellation of symptoms as she had had in the spring. She sought treatment and filed claims against Liberty and SAIF. The claims were denied.

Because claimant has an accepted claim for an "Anxiety Stress Reaction" condition with Liberty and she claims that her compensable condition has worsened, we first consider whether claimant has proven a compensable aggravation.

In order to establish a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation (the September 27, 1991 Determination Order). 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).

Drs. Legner, Gilmour, and Thompson, claimant's treating psychologist, family physician, and examining psychiatrist, respectively, agree that claimant's psychological condition worsened following her work exposure in the fall of 1991. (Tr. 189-190, original Ex. 17, Ex. 25). Drs. Legner and Gilmour further agree that claimant's prior work exposure (during Liberty's coverage) remains the major contributing cause of claimant's condition since October 1991. (Original Ex. 17; Tr. 189).

Dr. Sasser, treating psychiatrist, opined that claimant's personality was the primary cause of her problems in the fall of 1991. (Ex. 35-6). However, Dr. Sasser also opined that her work exposure at that time probably would not have "bothered" claimant, if she had not had previous work-related difficulties (in the spring of 1991). (Ex. 35-18). Although Dr. Thompson similarly opined that claimant's personality was the main cause of her current problems, he further indicated that the spring 1991 problems did contribute. (Ex. 31-55-56). In our view, the opinions of Drs. Thompson and Sasser do not controvert a finding that claimant's current problems are at least materially related to the accepted psychological condition.

Accordingly, we conclude that claimant has established that, at a minimum, Liberty's accepted claim remains a material contributing cause of claimant's current worsened psychological condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). In addition, based on Dr. Gilmour's November 4, 1991 release from work, we find that claimant was less able to work due to the worsened condition and, therefore, conclude that the worsening resulted in a diminished earning capacity. (Exs. 17, 19). Finally, because there was no permanent disability award, increased symptoms were not contemplated when the claim was closed in September 1991. Consequently, claimant has proven a compensable aggravation claim with Liberty. See ORS 656.273(1).

Responsibility

Under ORS 656.308(1), Liberty remains responsible for claimant's compensable psychological condition, unless claimant's work exposure during SAIF's later coverage is the major contributing cause of that condition. See ORS 656.308(1); SAIF v. Drews, 308 Or 1 (1993); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993);

Based on our review of the aforementioned evidence, we are not persuaded that claimant's exposure during SAIF's coverage is the major contributing cause of claimant's current stress-related psychological condition. Consequently, we find that claimant did not sustain a "new" occupational disease. ORS 656.308(1); SAIF v. Drews, supra. Under these circumstances, Liberty remains responsible for claimant's compensable psychological condition.

Claimant is entitled to an assessed attorney fee for services at hearing and on review for overturning Liberty'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 is $14,000, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and claimant's counsel's statements of services), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated July 6, 1993 is reversed in part and affirmed in part. That portion of the order that upheld Liberty Northwest Insurance Corporation's denial is reversed. Liberty's denial is set aside and the claim is remanded to Liberty for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $14,000, to be paid by Liberty.

May 24, 1994 Cite as 46 Van Natta 1008 (1994)

In the Matter of the Compensation of
JESS H. KNOWLAND, Claimant
WCB Case No. 93-06090
ORDER OF DISMISSAL
Scott Terrall & Associates, Defense Attorneys

Claimant has requested review of Referee Crumme's March 21, 1994 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Inasmuch as we find that claimant's request was not filed within 30 days of the Referee's order, we dismiss.

FINDINGS OF FACT

The Referee's Opinion and Order issued March 21, 1994. On April 21, 1994, claimant hand delivered a letter to the Portland Hearings Division requesting "that a retrial or appeal board be convened." On April 25, 1994, the Referee issued an order denying claimant's request to reopen the hearing. The order referred claimant's request to the Board to be processed as a request for review.

On April 29, 1994, the Board mailed a computer-generated letter to the parties acknowledging the request for review.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to 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 March 21, 1994 order was April 20, 1994. Claimant's request for Board review was hand-delivered to the Board on April 21, 1994. Inasmuch as claimant's request was not filed within 30 days of the Referee's March 21, 1994 order, it is untimely. Consequently, we lack authority to consider claimant's appeal.[1]

We are mindful that claimant 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).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] We further note that, on April 25, 1994, the Referee issued an "Order Denying Request to Reopen Hearing." That order included a statement explaining the parties' rights of appeal. Since the 30-day statutory period from the Referee's March 21, 1994 order had expired prior to issuance of his April 25, 1994 order, the Referee lacked authority to issue the April 25, 1994 order. Consequently, the April 25, 1994 order is a nullity. Leon C. Buzard, 40 Van Natta 595 (1988); see also Geer v. SAIF, 121 Or App 647 (1993) (Referee lacked authority to abate his initial order because more than 30 days had elapsed since initial order).

May 24, 1994 Cite as 46 Van Natta 1009 (1994)

In the Matter of the Complying Status of
KYOTO RESTAURANT, Employer
WCB Case No. 93-13698
ORDER OF DISMISSAL
Schneider, et al., Attorneys
Jini L. Roby, Attorney

Claimant, Kha T. Tran, requests Board review of Referee Lipton's order which approved a stipulation between the Director and Kyoto Restaurant, a noncomplying employer, affirming an order of noncompliance "without regard to the subjectivity and compensability of claimant, Kha T. Tran." Claimant seeks an assessed attorney fee award. We dismiss the request for lack of jurisdiction.

FINDINGS OF FACT

Kyoto Restaurant requested a hearing concerning the Deparment's order which found it to be a noncomplying employer. That hearing request was designated as WCB Case No. 93-13698.

The Department also referred claimant's injury claim to the SAIF Corporation for processing in accordance with ORS 656.054. SAIF denied claimant's low back injury claim. Claimant requested a hearing concerning SAIF's denial. That hearing request was designated as WCB Case No. 93-15264.

The two requests were consolidated for hearing. Over claimant's objection, the scheduled hearing was postponed at the request of Kyoto Restaurant. The postponement was granted because negotiations for settlement of all or a portion of the disputes were proceeding.

On March 18, 1994, the Referee approved a stipulation between the Department and Kyoto Restaurant. The stipulation provided that the noncomplying employer order was affirmed "without regard to the subjectivity and compensability of claimant, Kha T. Tran." Pursuant to the stipulation, Kyoto Restaurant's hearing request in WCB Case No. 93-13698 was dismissed.

On April 18, 1994, claimant mailed, by certified mail, her request for Board review of the stipulation. Asserting that she was a "party to the proceeding," claimant sought an assessed attorney fee award.

CONCLUSIONS OF LAW AND OPINION

An alleged noncomplying employer may contest the Department's order of noncompliance by filing a request for hearing with the Department pursuant to ORS 656.740. The order of the referee is deemed to be a final order of the Director. ORS 656.740(1) and (3). Jurisdiction for review of the referee's order is as provided in ORS 656.740(4).

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 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. Appellate jurisdiction rests with the court even if the Referee's order awards an assessed attorney fee. See Ace Tree Company, 46 Van Natta 880 (1994).

Here, Kyoto Restaurant only requested a hearing regarding the Department's noncomplying employer (NCE) order. That hearing request was initially consolidated with claimant's hearing request regarding SAIF's denial. However, prior to the commencement of that hearing, the Department and Kyoto Restaurant resolved their dispute regarding the NCE order. Consequently, Kyoto Restaurant's hearing request in WCB Case No. 93-13698 was dismissed pursuant to the Referee's stipulated order.

Claimant's hearing request in WCB Case No. 93-15264 was unaffected by the stipulation. Thus, the compensability issue arising from claimant's hearing request concerning SAIF's denial was separated from Kyoto Restaurant's hearing request regarding the NCE order. That separation occurred prior to hearing. In other words, claimant's hearing request currently remains pending before the Hearings Division.

Thus, the Referee's order approving the stipulation and dismissing Kyoto Restaurant's hearing request did not result from a hearing in which the issue of noncompliance was consolidated with a matter concerning a claim. See ORS 656.740(3)(c). Although at one time the two requests were consolidated for purposes of scheduling a hearing, no hearing was ever convened. Therefore, since the Referee's stipulated order of dismissal solely pertained to Kyoto Restaurant's appeal from the Director's noncompliance order, we lack appellate review authority. ORS 656.740(4)(c); Ferland v. McMurtry Video Productions, supra. Such review authority, including claimant's request for an assessed attorney fee award, rests with the Court of Appeals. See Ace Tree Company, supra.

The stipulation does provide that the NCE order is affirmed "without regard to the subjectivity and compensability of claimant." Nevertheless, the NCE order was solely confined to whether Kyoto Restaurant was a subject and noncomplying employer. Moreover, the stipulation affirmed that NCE decision. Finally, claimant's hearing request regarding SAIF's denial of the claim remains pending before the Hearings Division. Under such circumstances, appellate jurisdiction lies with the Court of Appeals under ORS 656.740(4).[1] Spencer House Moving, NCE, supra.

Consequently, the Referee's order constitutes a final order of the Department and must be

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[1] We interpret the "subjectivity and compensability" reference to be an acknowledgment that the stipulation regarding the dismissal of Kyoto Restaurant's hearing request from the Director's NCE order would have no effect on those matters. In other words, in light of claimant's pending hearing request from SAIF's denial, such matters (if in dispute) would await resolution when that hearing was convened and concluded.

appealed directly to the Court of Appeals. ORS 656.740(1), (3); ORS 183.480(1), (2); Ferland, supra; Spencer House Moving, supra; Jesus Fletes, et al, 45 Van Natta 2252 on recon 45 Van Natta 2376 (1993).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
VASILE MAIDANIVC, Claimant
WCB Case No. 93-01108
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Mills' order which reversed an Order on Reconsideration awarding 23 percent (73.6 degrees) unscheduled permanent disability for claimant's lumbar condition. In its brief on review, the self-insured employer contends that the Order on Reconsideration was procedurally invalid, and that the Department improperly excluded a medical arbiter opinion. On review, the issues are procedural validity of the Department's order, propriety of the Department's exclusion of the arbiter opinion, and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, except for his finding that claimant has no permanent impairment. We instead conclude that claimant is permanently restricted from repetitive bending and squatting.

CONCLUSIONS OF LAW AND OPINION

On October 6, 1992, the Department issued an Order on Reconsideration affirming a Determination Order awarding no permanent disability for claimant's low back injury. (Exs. 22, 28). This order was based on an arbiter opinion co-authored by Dr. Barth, who had previously participated in an employer-arranged medical examination (IME) in this claim.

The Department subsequently determined that its use of Dr. Barth as an arbiter violated its own rule for appointing medical arbiters. See OAR 436-10-047(2). For this reason, on January 6, 1993, the Department withdrew its initial order and reevaluated claimant's permanent disability based on a second medical arbiter report from Drs. Snodgrass and Dinneen. The Department awarded claimant a 5 percent value for a chronic low back condition under OAR 436-35-320(5), for a total award of 23 percent unscheduled permanent disability. The Department took this action under OAR 436-30-008, which authorizes withdrawal of an order if the Department has made an "inadvertent error or omission" affecting the order.

The employer then requested a hearing on the Department's January 6, 1993 order. At hearing, the employer argued that: (1) the Department acted improperly in excluding Dr. Barth's opinion; and (2) the Department's reliance on Dr. Barth's opinion was not the type of "error or omission" for which withdrawal is authorized under OAR 436-30-008.

The Referee concluded that the Department had acted correctly in withdrawing its initial order and rejecting Dr. Barth's arbiter opinion. Nevertheless, the Referee set aside the Department's award of 23 percent unscheduled permanent disability based on his conclusion that the preponderance of the medical evidence established that claimant had no ratable impairment.

On review, claimant asks the Board to reinstate the Department's 23 percent unscheduled permanent disability award, including the 5 percent impairment value for a chronic condition. The employer reiterates the procedural and evidentiary arguments made at hearing. It asks the Board to rate claimant's permanent disability based on Dr. Barth's medical arbiter report, rather than the second arbiter report from Drs. Snodgrass and Dinneen. The employer contends that Dr. Barth's report establishes that claimant has no injury-related permanent impairment.

Even if we were to consider Dr. Barth's report and exclude the subsequent opinion of Drs. Snodgrass and Dinneen, we would conclude that claimant is entitled to the 23 percent unscheduled permanent disability award granted by the reconsideration order. Accordingly, the procedural and evidentiary issues raised by the employer are not dispositive, and we need not address them.

Claimant's impairment is established by a preponderance of the medical evidence, based on the findings of the medical arbiter and the attending physician. ORS 656.245(3)(b)(B), ORS 656.268(7) and ORS 656.726(3)(f)(B). Here, Dr. Barth found that claimant had sustained no permanent impairment based on a medical arbiter examination on September 2, 1992. (Ex. 27). Claimant's attending physician, Dr. Hoppert, also reported that claimant was medically stationary as of May 4, 1992, without permanent impairment. (Ex. 19). At the same time, however, Dr. Hoppert also recommended that claimant not engage in repetitive pulling, twisting or stooping. Dr. Hoppert subsequently reiterated this restriction in a May 20, 1992 note to claimant's attorney. (Ex. 20).

We consider Dr. Hoppert's opinion as a whole and conclude that it supports an award for a chronic low back condition under OAR 436-35-320(5). We further conclude that Dr. Hoppert's findings are more persuasive than those of Dr. Barth. As claimant's long-time treating physician, Dr. Hoppert had greater familiarity with claimant's condition over time and was, therefore, in a better position to assess his long-term ability to repetitively use his lower back. In particular, Dr. Hoppert was in the best position to determine the extent to which claimant's loss of repetitive use was due to his compensable injury, as distinct from his documented functional overlay.

We, therefore, defer to the opinion of treating physician Hoppert and find that claimant is entitled to a 5 percent impairment value for a chronic condition under OAR 436-35-320(5). Neither party challenges the 18 percent value based on age, education and adaptability used by the Department in its January 6, 1993 order. (Ex. 29). Accordingly, we reinstate and affirm the Order on Reconsideration award of 23 percent unscheduled permanent disability.

Claimant's attorney is entitled to an assessed fee under ORS 656.382(2) because the employer requested a hearing on the Order on Reconsideration, and the Board has subsequently concluded that claimant's permanent disability compensation should not be disallowed or reduced. Thus, claimant has ultimately successfully defended against the employer's hearing request which attempted to reduce or eliminate claimant's permanent disability award granted by the Order on Reconsideration.

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 permanent disability issue is $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 hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 13, 1993 is reversed. The Order on Reconsideration award of 23 percent (73.6 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. For services at hearing regarding the employer's unsuccessful appeal of the Order on Reconsideration, claimant's attorney is awarded an assessed fee of $750, to be paid by the employer.

In the Matter of the Compensation of
RONALD NASARIO, Claimant
WCB Case No. 93-03275
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of that portion of Referee Bethlahmy's order finding that claimant's request for hearing regarding the compensability of a bilateral elbow condition was premature. On review, the issue is the procedural validity of claimant's request for hearing.

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

Claimant has an accepted claim for bilateral carpal tunnel syndrome. He asserts that, based on reports from his treating physician, Dr. Thomas, he also made a claim for bilateral elbow tendonitis and that the self-insured employer "de facto" denied that condition. Claimant thus maintains that the Referee improperly failed to address the compensability of the condition. The employer responds that, because claimant did not file a claim for an elbow tendonitis until shortly before the hearing, it did not "de facto" deny the claim and, therefore, claimant's request for hearing was prematurely filed. We agree with the employer.

The record shows that, while he was being treated for carpal tunnel syndrome, claimant complained of bilateral elbow pain. (Ex. 9-1). Although claimant continued to complain of elbow pain following carpal tunnel release surgeries, the diagnosis of carpal tunnel syndrome did not change, nor were any additional diagnoses provided until Dr. Thomas' June 3, 1993 report to claimant's attorney that claimant had tendonitis in his elbows that was the result of work exposure. (Exs. 12, 13, 16, 17, 19, 20, 24). Under these circumstances, we conclude that claimant did not make a claim for elbow tendonitis until the insurer received the June 3, 1993 report from Dr. Thomas. However, because the report issued within 90 days before the June 7, 1993 hearing, claimant's request for hearing is premature and ineffective and should be dismissed. E.g., Syphers v. K-W Logging, Inc., 51 Or App 769, 771, rev den 291 Or 151 (1981).

Having found that claimant's request for hearing with regard to elbow tendonitis should be dismissed as premature, we do not reach the issue of compensability of such condition.

ORDER

The Referee's order dated July 7, 1993 is affirmed.

In the Matter of the Compensation of
JAMES W. NICHOLLS, Claimant
WCB Case No. 91-01349
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. ITT Hartford Insurance Group v. Nicholls, 126 Or App 633 (1994). The court has reversed our prior order, which vacated a Referee's order that upheld the insurer's partial denials of claimant's claim for chiropractic treatment for the period from November 5, 1990 through January 23, 1991. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993) and Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Following a hearing, the Referee issued an order that upheld the insurer's January 25, 1991 and March 29, 1992 partial denials of claimant's claim for chiropractic treatment for the period from November 5, 1990 through January 23, 1992. In upholding the denials, the Referee reasoned that chiropractic treatments from November 5, 1990 through December 19, 1990 are not reimbursable under ORS 656.245(3)(b)(A), because Dr. Ordonez (who was claimant's attending physician for the compensable injury at least from August 1, 1990 through December 17, 1990) authorized no such treatment in writing. In addition, even assuming that Dr. Nicholson became claimant's attending physician before claimant's December 19, 1990 chiropractic treatment, the Referee found that treatment nonreimbursable, because it was similarly unauthorized. Finally, the Referee found claimant's January 23, 1991 chiropractic treatment nonreimbursable, because it was not carried out under a written treatment plan prescribed by the attending physician prior to the start of treatment, as required by OAR 436-10-040(3)(b) (effective December 26, 1990).

Claimant requested Board review. We vacated the Referee's order, based on a finding that we lacked jurisdiction over matters concerning whether treatment had been approved by an "attending physician" and whether treatment was palliative or curative.

The insurer requested judicial review of our decision. The court held that we have jurisdiction to resolve this dispute because no party sought review by the Director. ITT Hartford Insurance Group v. Nicholls, supra. Relying on Meyers v. Darigold, supra and Theodore v. Safeway Stores, Inc., supra, the court has reversed and remanded this case for reconsideration. Accordingly, we proceed with our reconsideration.

Chiropractic Treatments from November 5, 1990 through December 19, 1990

Chiropractic treatments provided more than 30 days after a compensable injury or after 12 treatments (whichever occurs first) are not reimbursable absent written authorization from the worker's attending physician. See ORS 656.245(3)(b)(A). ORS 656.005(12)(b) defines an "attending physician" as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." See OAR 436-60-005(2). Whether a physician qualifies as an "attending physician" is a question of fact. See Christine Sutton, 45 Van Natta 192, 193 (1993); Paula J. Gilman, 44 Van Natta 2539 (1992).

In this case, Dr. Stassi was claimant's longtime treating chiropractor. On June 29, 1990, claimant signed an "829" form, identifying Dr. Nicholson, family physician, as his attending physician. (Ex. 34). Dr. Nicholson referred claimant to Dr. Ordonez, neurological surgeon. On August 6, 1990, the insurer received another "829" form, which identified Dr. Ordonez as claimant's attending physician. (Ex. 39).

Dr. Ordonez prescribed injection therapy for claimant and advised Dr. Nicholson concerning claimant's condition periodically. (See Exs. 40, 51, 59, 63, 69, 73). On July 30, 1990, Dr. Nicholson noted that claimant was seeing Dr. Ordonez "in consultation" and that Dr. Ordonez should be contacted concerning claimant's then-current physical capacities. (Ex. 44). On September 21, 1990, Dr. Nicholson informed the insurer that he had "left [claimant's] work determination, his stability, etc., up to Dr. Ordonez" and suggested that the insurer contact Dr. Ordonez for further information. (Ex. 55; see Ex. 52).

By letter dated November 27, 1990, Dr. Ordonez notified Dr. Nicholson of claimant's request to be returned to Dr. Nicholson's care "for follow up." (Ex. 73-1). Expecting that claimant would return to Dr. Nicholson three weeks after November 27, 1990, Dr. Ordonez stated, "I am sending him to you at his request, but warn you that he might like to play some type of game with you too." (Ex. 73-2).

Thereafter, Dr. Nicholson apparently examined claimant on December 24, 1990 and released him to modified work as of January 2, 1991. (Ex. 78). On January 2, 1991, claimant resigned from his job, due to his physical condition. (Ex. 81).

On March 18, 1991, the insurer received Dr. Nicholson's recommendation for 12 weeks' additional chiropractic care. (Ex. 93). On May 20, 1991, the insurer received Dr. Nicholson's recommendation for 8 weeks' additional chiropractic care. (Ex. 98).

On this record, it is clear to us that Dr. Ordonez was the physician primarily responsible for prescribing treatment for claimant's back condition for the period following the August 1990 "829" form at least until December 24, 1990. (In fact, we find no indication that Dr. Nicholson even examined claimant during this time.) Accordingly, we find that Dr. Ordonez was claimant's attending physician from August 6, 1990 until at least December 24, 1990. Furthermore, finding no indication that Dr. Ordonez authorized the disputed chiropractic treatments (from November 5, 1990 through December December 14, 1990), we conclude that claimant has not established that the treatments are reimbursable under ORS 656.245(3)(b)(A).

We also agree with the Referee that the record does not establish that claimant's December 19, 1990 treatment is reimbursable. In other words, even if Dr. Nicholson became claimant's attending physician sometime after November 27, 1990, Dr. Nicholson did not provide written authorization for treatment as required by ORS 656.245(3)(b)(A). Accordingly, we adopt the Referee's opinion on this issue.

January 23, 1991 Chiropractic Treatment

We adopt the Referee's opinion on this issue, with the following comment.

Even assuming that Dr. Nicholson was claimant's attending physician by January 1991, we find no evidence that Dr. Nicholson authorized claimant's January 23, 1991 chiropractic treatment in writing as required by ORS 656.245(3)(b)(A). See also OAR 436-10-040(3)(a)&(b); compare Danny S. Johns, 46 Van Natta 278 (1994) (Where the treating physician's objectives for the disputed treatment were ascertainable, strict compliance with a rule requiring a treatment plan was not necessary).

Accordingly, on reconsideration of our August 31, 1992 order, as reconsidered on October 15, 1992, the Referee's order dated November 20, 1991 is affirmed.

IT IS SO ORDERED.

May 24, 1994 Cite as 46 Van Natta 1015 (1994)

In the Matter of the Compensation of
CARLA R. SPELLMAN, Claimant
WCB Case No. 93-01202
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Hazelett's order that affirmed an Order on Reconsideration awarding claimant no scheduled permanent disability (PPD) for loss of use or function of the right thumb (hand), and 5 percent (16 degrees) unscheduled permanent disability for a low back injury. On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

We adopt and affirm the Referee's opinion on this issue, with the following comment.

On review, claimant contends that she has established entitlement to a chronic condition award based on her credible testimony that she has ongoing complaints and limitations in her right hand that came on immediately following her work injury and have been present continuously since. We disagree.

Permanent impairment is established by a preponderance of the medical evidence, considering the arbiter's examination as well as any prior relevant impairment findings. See OAR 436-35-010(6); Carlos S. Cobian, 45 Van Natta 1582 (1993); Raymond L. Owen, 45 Van Natta 1528 (1993). Lay testimony is insufficient to establish permanent impairment under the "standards." See OAR 436-35-005(5); Patricia A. Avila, 45 Van Natta 2094 (1993); William K. Nesvold, 43 Van Natta 2767 (1991).

Unscheduled Permanent Disability

Claimant seeks an increased unscheduled PPD award based on additional values for impairment (lost thoracolumbar range of motion) and consideration of the adaptability factor. We adopt and affirm the Referee's conclusions and reasoning that claimant's loss of earning capacity does not exceed that compensated by the Order on Reconsideration, with the following supplementation.

Impairment

Unless a preponderance of the evidence from the attending physician indicates otherwise, the arbiter's report is to be used to rate permanent disability. OAR 436-35-007(9). Here, a medical arbiter, Dr. Stanford, was appointed. Thus, both treating physician Dr. Ushman's closing examination and Dr. Stanford's arbiter's report may be considered in rating claimant's permanent disability.

Dr. Ushman examined claimant on June 16, 1992. He noted that claimant no longer had any back complaints. Dr. Ushman measured full thoracolumbar ranges of motion, opined that claimant was medically stationary without impairment, and released claimant to return to her regular job.

In December 1992, claimant fell and injured her back. She developed new symptoms that continued through the date of hearing. Thereafter, in January 1993, Dr. Stanford examined claimant. He measured lost thoracolumbar flexion, extension, and right lateral flexion.

On review, claimant contends that the Referee should have relied on Dr. Stanford's arbiter report rather than on Dr. Ushman's closing report to award claimant additional permanent disability. For the reasons expressed by the Referee, we too are persuaded that Dr. Ushman's evaluation more accurately reflects claimant's permanent impairment due to the compensable injury. We conclude, therefore, that claimant has failed to establish that her lost thoracolumbar ranges of motion are attributable to the compensable injury.

The criteria for rating unscheduled PPD is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). As we have found herein, the preponderance of the evidence from the attending physician indicates that claimant has no low back impairment compensably related to the industrial injury. Accordingly, claimant is not entitled to any impairment value for loss of thoracolumbar range of motion. However, since the insurer has not cross-appealed claimant's award of 5 percent unscheduled permanent disability, on review, we will not reduce it. Daniel M. Alire, 41 Van Natta 752 (1989).

Adaptability

Citing England v. Thunderbird, 315 Or 633 (1993), claimant contends that the Referee erred in failing to consider the adaptability value.

In response to the Supreme Court's decision in England, supra, the Director promulgated temporary rules concerning age, education and adaptability (WCD Admin. Order 93-052). However, those temporary rules expired on December 14, 1993. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2); See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant became medically stationary on June 12, 1992, and her claim was closed by Notice of Closure on June 22, 1992. Since claimant became medically stationary after July 1, 1990, and made a request for reconsideration pursuant to ORS 656.268, the applicable standards are those in effect on the

date of the Notice of Closure. OAR 438-10-010; 436-35-003(2); WCD Admin. Order 6-1992; WCD Admin. Order 93-056. Thus, the issue is what value for adaptability, if any, claimant is entitled to under the relevant standards.

The pertinent administrative rule is OAR 436-35-310(2) (WCD Admin. Order 6-1992), which provides that, for workers that have a release to regular work or have either returned to or have the residual functional capacity to perform regular work, the value for the factor of adaptability is zero. Here, claimant's at-injury job was a fry cook. She was released by her attending physician, Dr. Ushman, to her regular work with no restrictions. Similarly, the medical arbiter, Dr. Stanford, noted that he would not place any restrictions on claimant's work activities.

Accordingly, since claimant was released to and returned to her regular fry-cook job duties without restriction, we conclude that her adaptability value is zero under the applicable standards. See Mark S. Lillibridge, 46 Van Natta 411 (1994). Because the adaptability factor is a multiplier, the product of claimant's age and education factors with her adaptability equals zero.

Therefore, claimant's unscheduled permanent disability is based on impairment alone. Consequently, as did the Referee, we affirm the Order on Reconsideration awarding claimant 5 percent unscheduled PPD.

ORDER

The Referee's order dated June 30, 1993 is affirmed.

May 24, 1994 Cite as 46 Van Natta 1017 (1994)

In the Matter of the Compensation of
JANE A. VOLK, Claimant
WCB Case No. 92-06678
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On May 2, 1994, we withdrew our April 1, 1994 Order on Review which held that claimant's counsel was entitled to an "out-of-compensation" attorney fee, but, since the compensation had previously been paid to claimant, declined to direct the insurer to pay the fee directly to claimant's counsel. We took this action in order to consider claimant's contentions that our decision was inconsistent with several appellate court holdings and contrary to OAR 438-15-085(2). The time having expired within which to respond to claimant's motion, we proceed with our reconsideration.

Claimant essentially raises three arguments on reconsideration. One, we have misinterpreted the holding of Lebanon Plywood v. Seiber, 113 Or App 651 (1992). Two, our reliance on Johnson v. Capitol Car Wash, 127 Or App 49 (1994) is misplaced. And three, our decision is contrary to OAR 438-15-085(2).

As demonstrated by our prior order, we have fully considered the Seiber holding and its effect on the issue before us. For the reasons expressed in our decision, we continue to conclude that, since claimant has previously received the permanent disability compensation granted by the Referee's order, we would be creating an "administrative overpayment" to require the insurer to pay to claimant's counsel the "out-of-compensation" fee allowable from that "increased" award and then authorizing the employer to recover this "overpayment" from claimant's future permanent disability awards. Since Seiber prohibits the creation of "administrative overpayments," we are without authority to take such an action.

In other words, whether these additional sums are characterized as an "attorney fee" or "additional compensation," the fact remains that a decision ordering the payment of such sums and authorizing the recovery of these "overpaid" benefits from claimant's future compensation constitutes the creation of an "administrative overpayment" which violates the Seiber rationale. This conclusion that an "out-of-compensation" attorney fee constitutes "compensation" is also consistent with the general proposition advanced by the Johnson holding. Our reference to Johnson was not intended to suggest

that the decision was controlling. Rather, its citation was designed to support the concept that "out-of-compensation" attorney fees are included within "compensation," they are not an addition to a claimant's compensation.

As we have previously explained, because claimant has already received the "increased" permanent disability award and since claimant's counsel is entitled to a portion of that award as an "out-of-compensation" attorney fee, her counsel must seek recovery of that fee from claimant. Such a procedure is not only consistent with all statutory and administrative rule requirements, but it conforms with claimant's executed retainer agreement.

Finally, we disagree with claimant's assertion that our decision violates OAR 438-15-085(2), which prohibits the application of an offset for prior overpayments of compensation before allowance of an "out-of-compensation" attorney fee award.[1] As reasoned in our prior decision (footnote 3), had we determined that claimant's counsel was not entitled to an attorney fee, such a conclusion would have been contrary to the aforementioned rule. Here, we have concluded just the opposite; i.e., claimant's counsel is entitled to an "out-of-compensation" attorney fee. Nevertheless, since the compensation is already in claimant's possession, counsel must seek payment either directly or indirectly from her.

Accordingly, as supplemented herein, we republish our April 1, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Members Hall and Gunn dissenting.

For the reasons set forth in our dissenting opinion in the prior order, we adhere to our position that the carrier should be directed to pay the out-of-compensation attorney fee directly to claimant's counsel.

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[1] Claimant also contends that "[t]he notion that permanent partial disability compensation can be, or is, pre-paid, rather than overpaid, is found no-where [sic] in the statute or administrative rules." As examples of this "notion," we direct claimant's attention to ORS 656.268(13), which provides that any determination or notice of closure may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made . . ." (Emphasis supplied). In addition, claimant may wish to examine OAR 436-30-020(12)(a) and 436-30-030(16)(a), which provide for the allowance of adjustments in carrier and Department claim closures to "recover payments for permanent disability which were made prematurely." (Emphasis supplied).

May 24, 1994 Cite as 46 Van Natta 1018 (1994)

In the Matter of the Compensation of
DARWIN G. WIDMAR, Claimant
WCB Case Nos. 92-14972, 92-08588 & 92-09333
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Bottini, et al., Defense Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Alexsis Risk Management (Alexsis) requests review of those portions of Referee Hazelett's order which: (1) set aside its "back up" denial of claimant's March 1991 low back injury claim; (2) set aside its denial of claimant's "aggravation/new injury" claim for his November 1991 low back condition; and (3) upheld Liberty Northwest Insurance Corporation's denials of claimant's current low back condition. On review, the issues are "back up" denial, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and offer the following summary of the relevant facts.

Claimant, a municipal services worker, sustained a compensable low back injury in 1985 while the employer, the City of Hermiston, was insured by Liberty. Dr. Feinberg, a chiropractor, treated claimant for low back, left hip and leg pain. Claimant returned to work after two months of temporary disability. The claim was closed by Notice of Closure on March 6, 1986 with an award of temporary disability only.

Claimant experienced subsequent exacerbations of his low back condition in 1986 and 1987. A Determination Order was issued on August 7, 1987, which awarded 5 percent unscheduled permanent disability. Claimant continued to treat with Dr. Feinberg.

In November 1988, claimant again experienced an episode of increased back pain with radiation to his left foot and right knee. Liberty continued to reimburse claimant for his chiropractic treatment. Claimant returned to work in December 1988 and his left leg pain resolved.

On March 11, 1991, claimant lifted two street signs and had a sudden onset of low back pain. At this time, the City of Hermiston was self-insured, with Alexsis processing its claims. Alexsis accepted a lumbar strain on April 29, 1991. (Ex. 45). Dr. Feinberg provided additional chiropractic treatment with the authorization of Dr. Oltman, a Hermiston physician. Claimant also consulted Drs. Pettee and Veale. Claimant returned to work on March 19, 1991.

A Determination Order issued on September 4, 1991, awarding claimant temporary disability only. Claimant continued his regular work until he experienced still another flareup of low back pain on November 25, 1991, when he picked up wooden barricades. Claimant sought treatment from Dr. Carlson, who diagnosed a low back strain.

Subsequently, both Liberty and Alexsis denied compensability and responsibility with respect to the November 1991 incident. On January 11, 1993, Alexsis issued a "back up" denial of the March 11, 1991 accepted claim on the grounds that Liberty was responsible for the payment of benefits.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that Alexsis could not retroactively disclaim responsibility for the March 1991 injury under ORS 656.308. Accordingly, the Referee found Alexsis responsible for the March 1991 injury as a matter of law. Regarding the November 1991 claim, the Referee found that the preponderance of the medical evidence established that claimant's low back condition was compensable. Reasoning that the November 1991 incident was either a temporary symptomatic worsening of the March 1991 injury or a new injury to the same body part, the Referee found that Alexsis was responsible for the payment of benefits relating to claimant's condition in November 1991.

Although we agree that Alexsis is responsible for claimant's low back condition in March 1991 and thereafter, we disagree with the Referee's analysis.

As Alexsis correctly notes, ORS 656.262(6) specifically allows "back up" denials to the extent such denials are issued by a "paying agent."[1] However, paying agents are appointed pursuant to ORS 656.307. See OAR 436-60-180. Inasmuch as no paying agent was ever appointed in this claim, and since Alexsis is not challenging the compensability of claimant's claim, ORS 656.262(6) is not applicable. Moreover, Alexsis failed to timely disclaim responsibility under ORS 656.308 within 30 days of being "named or joined" in the claim. For this additional reason, Alexsis' "back up" denial of responsibility was invalid.

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[1] ORS 656.262(6) provides:

"Written notice of acceptance or denial 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 the 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." (Emphasis supplied).

Alternatively, even if Alexsis were not precluded from revoking its acceptance of the March 1991 claim, ORS 656.262(6) requires that a "back up" denial be based on "later obtain[ed] evidence" that it was not responsible for the claim. See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993). To constitute later obtained evidence, the statute requires that there be something other than evidence the insurer had at the time of the initial acceptance. A reevaluation of known evidence does not constitute "later obtain[ed] evidence" under ORS 656.262(6). Id. at 286.

Alexsis contends that a March 27, 1991 letter from Dr. Feinberg to Dr. Oltman, which was not received until after its April 29, 1991 acceptance of the March 1991 injury, as well as a July 9, 1992 medical report from Drs. Lynch and Powell, examining physicians for Liberty, constitute "later obtain[ed] evidence." We disagree.

Prior to its April 29, 1991 acceptance, Alexsis was aware that Dr. Feinberg was treating claimant. Dr. Feinberg had submitted a form 829 to Alexsis on April 10, 1991. (Ex. 41). Before accepting the claim, Alexsis could have requested records from Alexsis and obtained Dr. Feinberg's March 27, 1991 letter to Dr. Oltman. In that letter, Dr. Feinberg stated that it was "not unreasonable" that claimant's back condition constituted an aggravation of his 1985 Liberty injury, rather than a new injury. (Ex. 36A).

In addition, Dr. Feinberg subsequently wrote Dr. Oltman on July 30, 1991, directing him to write to Alexsis and state that chiropractic treatment in April and May 1991 was related to an "injury" claimant sustained on March 11, 1991. (Ex. 52A-2). Finally, the July 1992 medical report from Drs. Powell and Lynch states that the March 1991 injury was a "mild temporary aggravation" of preexisting degenerative changes. (Ex. 79).

All of these reports were obtained by Alexsis subsequent to its April 29, 1991 acceptance. Nevertheless, each report represents a reevaluation of claimant's condition and its relationship to claimant's 1985 accepted claim and the March 1991 work incident. Moreover, Dr. Feinberg's July 1991 report does not even support a conclusion that Alexsis was not responsible for claimant's condition in March 1991. Finally, the July 1992 report from Drs. Powell and Lynch does not provide evidence that the March 1991 incident was an aggravation of the 1985 Liberty low back claim. Accordingly, we do not consider that the aforementioned reports constitute "later obtain[ed] evidence" for the purposes of ORS 656.262(6). CNA Ins. Co. v. Magnuson, supra.

Assuming arguendo that sufficient later obtained evidence existed to justify a "back up" denial, Alexsis must still prove by "clear and convincing" evidence that it was not responsible for the March 1991 claim. ORS 656.262(6). To satisfy this legal standard, Alexsis would have to prove that it was "highly probable" that a new injury did not occur, i.e., that the March 1991 incident was not the major contributing cause of claimant's disability or need for treatment. See Drews v. SAIF, 318 Or 1 (1993); Riley Hill General Contractors v. Tandy Corp., 303 Or 390, 407 (1987). The medical record falls far short of that necessary to constitute "clear and convincing" evidence.

As previously noted, the medical report of Drs. Powell and Lynch does not establish that the March 1991 incident was an aggravation of the 1985 Liberty claim. Dr. Feinberg's medical reports cited above are inconsistent, with his July 1991 medical report actually supporting the position that a "new injury" occurred in March 1991. Dr. Oltman merely wrote reports in accordance with Dr. Feinberg's instructions. (Exs. 38, 53). We also note that Dr. Pettee opined that the March 11, 1991 incident was the major contributing factor in claimant's low back condition. (Ex. 40) This report, which was in Alexsis' possession prior to its acceptance of the March 1991 claim, and which indicates that Alexsis was responsible for the March 1991 incident, would also not constitute clear and convincing evidence supporting Alexsis' "back up" denial.

In conclusion, we find that Alexsis' revocation of its April 29, 1991 acceptance of the March 1991 claim was invalid. Accordingly, we find that the Referee correctly held that its "back up" denial was impermissible, although not for the reasons cited in the Referee's order. Moreover, even if the denial was permissible, Alexsis does not establish by "clear and convincing" evidence that it was not responsible for payment of benefits concerning the March 1991 claim.

Having found Alexsis responsible for the March 1991 claim, the Referee correctly concluded that Alexsis is also responsible for claimant's November 1991 disability and need for treatment. As the insurer responsible for the most recent accepted claim for claimant's low back condition (the March 1991 claim), Alexsis would also be responsible for future compensable medical services and disability for the compensable condition. See ORS 656.308; Smurfit Newsprint v. Derosset, 118 Or App 368, 371 (1993).

We agree for the reasons mentioned in the Referee's order that claimant's November 1991 low back condition is compensable. Moreover, the Referee found, and Alexsis concedes, that claimant's condition in November 1991 was the "same condition" as involved in the March 1991 injury. Therefore, we find that Alexsis is responsible for claimant's November 1991 low back condition under its March 1991 claim. See ORS 656.308(1); Smurfitt Newsprint v. Derosset, supra.

Alexsis does not contest the Referee's finding that it denied the compensability of claimant's November 1991 claim. Because of Alexsis' compensability denial, claimant's compensation remained at risk on Board review. Consequently, claimant's counsel is entitled to an attorney fee for his services on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by Alexsis. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 15, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by Alexsis.

In the Matter of the Compensation of
FRANCISCO J. DELACERDA, Claimant
WCB Case No. 93-07956
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of Referee Emerson's order which: (1) directed it to resume payment of temporary total disability; and (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Termination of Temporary Total Disability

The Referee found that the insurer improperly reduced claimant's temporary total disability to temporary partial disability based on claimant's refusal of modified work. See ORS 656.268(3)(c).[1] Specifically, the Referee concluded that the offer of modified work was "contingent" since there was no evidence in the record that the modifications to the proposed job were ever accepted by the modified-work employer. In addition, the Referee determined that the attending physician never provided a release to return to modified work.

We agree with the Referee that the modified work release was no more than a contingent offer of modified work. We likewise agree that the attending physician never provided a modified work release.

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[1] ORS 656.268(3)(c) provides for the termination of temporary total disability when "the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Dr. Stringham was claimant's attending physician, not Dr. French, the physician who authored the release to modified work. The "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Here, claimant filed a form 829 designating Dr. Stringham as the attending physician. (Ex. 9). In addition, claimant testified that Dr. Stringham was his attending physician. (Tr. 9). Although claimant's testimony is not dispositive, it is a significant factor in determining the identity of claimant's attending physician. See Christine Sutton, 45 Van Natta 192, 193 (1993).

There are additional indications that Dr. Stringham was claimant's attending physician elsewhere in the record. For instance, Dr. Stringham coordinated the various referrals to other physicians involved in claimant's care. Dr. French's weekly report referred to Dr. Stringham as the "primary physician" after the latter doctor terminated claimant's physical therapy while claimant participated in Dr. French's Functional Activity Short Term (FAST) program. (Ex. 20). Moreover, Dr. Stringham's treatment continued during the time claimant was engaged in the FAST program. (Ex. 19).

In conclusion, the record supports the Referee's finding that Dr. Stringham remained claimant's attending physician. Inasmuch as Dr. Stringham did not provide claimant's release to modified work, as required by ORS 656.268(3)(c), we agree that the insurer improperly terminated claimant's temporary total disability.

The insurer contends, however, that Dr. Stringham "delegated" the responsibility for providing work releases to Dr. French. The insurer cites the June 23, 1993 medical report in which Dr. Stringham deferred work issues to Dr. French and Dr. Stringham's August 19, 1993 concurrence letter which acknowledges that he refers matters of work releases to Dr. French while patients are in the FAST program. (Exs. 19, 22).

The insurer's contentions notwithstanding, ORS 656.268(3)(c) specifically states that it is the attending physician who is supposed to provide the modified work release. There is no "delegation" provision in the statute. Although Dr. Stringham subsequently agreed with the modified work release (Ex. 22), he neither authored the release nor signaled his agreement with it before the modified position was effective on June 17, 1993. Even assuming that the statute allows an attending physician to "delegate" the responsibility of providing a work release, the delegation to Dr. French in this case did not occur until June 23, 1993, after claimant was to begin the modified job.

For these reasons, we reject the insurer's "delegation" argument. Thus, we affirm the Referee's order finding that the insurer's termination of temporary total disability was improper.

Penalty and Attorney Fees

The Referee also held that the insurer's termination of temporary total disability was unreasonable and assessed a 25 percent penalty pursuant to ORS 656.262(10). We disagree.

Although we have affirmed the Referee's determination that the insurer's reduction of temporary total disability was invalid, we do not find that it was unreasonable. The insurer could reasonably have considered Dr. French to be the appropriate physician to provide a work release given Dr. Stringham's deferral to Dr. French with regard to return-to-work issues. Moreover, Dr. French's initial report indicated matters of modified duty were part of his case management. Accordingly, we conclude that the insurer had a reasonable basis for terminating claimant's temporary total disability. Thus, we reverse the Referee's penalty assessment.

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

ORDER

The Referee's order dated October 7, 1993 is affirmed in part and reversed in part. That portion which awarded a penalty for allegedly unreasonable claim processing is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the insurer.

May 24, 1994 Cite as 46 Van Natta 1023 (1994)

In the Matter of the Compensation of
ROBERT D. KNUTSON, Claimant
WCB Case Nos. 93-07273, 93-07053, 93-04069 & 93-04651
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys
Jerome Larkin (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Security Insurance Company of Connecticut (EBI) requests review of Referee Lipton's order which: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld the denials of the SAIF Corporation, on behalf of Cheolone Farms, and Liberty Northwest Insurance Corporation, on behalf of Shilo Inn, for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work activities in February 1993 were a material contributing cause of his low back condition and need for treatment. The Referee, therefore, concluded that SAIF had proven that claimant sustained a new compensable injury, thereby shifting responsibility to EBI.

Subsequent to the Referee's order, the Supreme Court held that ORS 656.005(7)(a)(B) applied in the responsibility context to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. SAIF v. Drews, 318 Or 1 (1993). The Supreme Court 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 only 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 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).

Here, the evidence establishes that claimant has had a chronic and recurring condition since 1985. Claimant initially injured his low back on October 28, 1985 in a slip and fall accident, while working for SAIF's insured. SAIF accepted a sacroiliac and lumbosacral sprain/strain and a subsequent L5-6 disc herniation, which resulted in surgery. The claim was ultimately closed by a May 22, 1989 Determination Order, which awarded 24 percent unscheduled permanent disability.

Following his 1985 injury and his 1988 surgery, claimant continued to experience low back and left leg pain. Claimant testified that, in February 1993, he noticed an increase in his symptoms while removing toilets. He did not experience any new symptoms, but rather a gradual worsening of symptoms. (Tr. 8-10, 17-18).

Dr. Gerry, claimant's treating physician, diagnosed claimant's condition as a recurrent disc herniation. Dr. Gerry opined that claimant's February 1993 work activities caused a worsening of his preexisting condition (disc herniation) rather than a separate injury distinct from his 1985 injury, and

that these work activities were the major contributing cause for the worsened condition and need for treatment. We construe his opinion as establishing that claimant's February 1993 work activities combined with his preexisting compensable condition, but that the preexisting condition no longer remained the major contributing cause of claimant's current condition.

Dr. Waller, who performed claimant's 1988 and 1993 surgeries, compared claimant's 1989 MRI scan, which showed some degenerative changes and post-operative epidural fibrosis, to his March 24, 1993 MRI scan, which demonstrated a recurrent disc herniation at L5-L6. After a myelogram and post-contrast CT scan confirmed the findings of a recurrent disc herniation at L5-L6, Dr. Waller performed surgery. The surgery findings indicated that a very swollen S1 nerve root, rather than a large disc herniation, accounted for most of the abnormalities seen on the radiographic studies. However, Dr. Waller's post-operative diagnosis remained recurrent left L5-L6 disc herniation. (Exs. 66, 69, 81). Dr. Waller subsequently opined that claimant's preexisting back condition (previous left L5-L6 disc herniation) combined with claimant's February 1993 work activities and remained the major contributing cause of his worsened condition and need for treatment. (Ex. 81).

As the physician who performed claimant's surgeries, Dr. Waller is in the best position to provide an opinion regarding the cause of claimant's current condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Dr. Waller also had an opportunity to examine and treat claimant before and after the "new injury" incident, and therefore is in a better position than Dr. Gerry, who first saw claimant on March 24, 1993, to compare claimant's condition. See Roff v. Georgia Pacific Corporation, 80 Or App 78 (1986). Accordingly, we give his opinion greater weight than that of Dr. Gerry.

Therefore, the persuasive medical evidence establishes that claimant's preexisting compensable condition, for which SAIF is responsible, is and remains the major contributing cause of his current low back condition. Because SAIF has failed to establish a new compensable injury while Liberty or EBI were on the risk, responsibility does not shift.

Given our conclusion that SAIF remains responsible for claimant's condition, we need not address EBI's contention that claimant was an employee of Liberty's insured.

Attorney Fees

At hearing, SAIF and EBI denied both compensability and responsibility. Liberty only denied responsibility. Due to SAIF's and EBI's compensability denials, claimant's right to compensation was at risk at hearing. Because we have concluded that SAIF is responsible for claimant's condition, SAIF is also responsible for payment of the $2,000 assessed attorney fee awarded at hearing. Tanya L. Baker, 42 Van Natta 2818, 2819 (1990).

Further, given our de novo review authority, claimant's compensation remained at risk on Board review. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review. Because EBI sought Board review, EBI is responsible for the assessed attorney fee for claimant's counsel's services on Board review. Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990); Tanya L. Baker, supra. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $250, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 21, 1993 is reversed. EBI's June 16, 1993 denial is reinstated and upheld. The SAIF Corporation's March 29, 1993 and May 27, 1993 denials are set aside and the claim is remanded to SAIF for processing according to law. The Referee's $2,000 assessed attorney fee award shall be paid by the SAIF Corporation, rather than EBI. Claimant's attorney is awarded $250 for services on Board review, to be paid by EBI.

In the Matter of the Compensation of
THOMAS M. ALDRICH, Claimant
WCB Case No. 91-13459
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Black's order that declined to award additional temporary disability. With his brief, claimant has submitted additional documents and requests that the Board consider these documents on review. We treat such a request as a motion to remand. On review, the issues are temporary disability and remand. 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

With his brief, claimant has submitted additional documents and requests that the Board consider these documents on review. We treat such a request as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985). These additional documents consist of copies of two pages from the Dictionary of Occupational Titles.

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

Here, we find that the copies of pages from the Dictionary of Occupational Titles were obtainable with the exercise of due diligence at the time of the hearing. In addition, we do not consider the present record, without these documents, to be improperly, incompletely, or insufficiently developed. Moreover, we do not find that admission of these documents would likely affect the outcome of the case. For these reasons, claimant's motion to remand is denied.

Temporary Disability

In his initial order, the Referee relied on Lebanon Plywood Company v. Seiber, 113 Or App 651 (1992), in determining that claimant was not entitled to temporary total disability benefits after February 8, 1991, the date he became medically stationary. Claimant requested reconsideration of the Referee's order. In his Order on Reconsideration, the Referee continued to conclude that claimant was not entitled to additional temporary total disability benefits. However, he based his conclusion on a determination that the requirements of ORS 656.268(3) were met, which enabled the insurer to unilaterally terminate payment of temporary disability benefits.

On review, claimant argues that the insurer was not entitled to unilaterally terminate payment of temporary disability benefits because the requirements of ORS 656.268(3) were not met. Specifically, claimant argues that his attending physician's release to work on "a trial basis" as a fabricator was too tentative to constitute a "release" within the meaning of ORS 656.268(3)(b). In addition, claimant argues that the release to work as a fabricator was not a release to return to "regular employment" pursuant to ORS 656.268(3)(b) because his at-injury job was a sheet metal worker.

We need not address the issue of whether claimant's attending physician's release to return to work met the requirements of ORS 656.268(3)(b), thus entitling the insurer to unilaterally terminate claimant's temporary disability benefits. ORS 656.268(3) applies to claimant's procedural entitlement to

temporary disability benefits. Here, because claimant has been determined medically stationary and his claim has been closed, the issue is claimant's substantive entitlement to temporary disability benefits. Thus, we find the Referee's initial reliance on Seiber was correct.

As the court noted in Lebanon Plywood Company v. Seiber, supra, a worker is substantively entitled to temporary total disability benefits from the onset of disability until the condition becomes medically stationary. The court recognized that, due to delays in claims processing, the actual payment of such benefits often continues until the determination order is issued, thus creating a procedural overpayment. Nonetheless, the court explained that, in such cases, the payment of benefits past the medically stationary date is a consequence of the administrative process of claim closure and not an entitlement. Thus, it concluded that an overpayment cannot be imposed if the processing delay fails to produce one.

Here, the claim was closed by a June 4, 1991 Determination Order, which found claimant's condition medically stationary as of February 8, 1991. An October 22, 1991 Order on Reconsideration affirmed that finding. Claimant did not raise the issue of his medically stationary date at hearing. Thus, claimant is substantively entitled to temporary disability benefits through February 8, 1991.

Although there is some dispute as to whether claimant was released to return to regular work, it is clear that the insurer paid temporary disability benefits through the February 8, 1991 medically stationary date, but not beyond that date. (Ex. 16A-5). Accordingly, claimant has received all of the temporary disability benefits to which he is entitled and there was no overpayment of benefits beyond the medically stationary date. We may not impose an overpayment of benefits past the medically stationary date. Lebanon Plywood Company v. Seiber, supra; Harley J. Gordineer, 44 Van Natta 1673 (1992).

ORDER

The Referee's order dated June 3, 1993, as reconsidered August 17, 1993, is affirmed.

May 26, 1994 Cite as 46 Van Natta 1026 (1994)

In the Matter of the Compensation of
BARBARA A. FLEMING, Claimant
WCB Case No. 91-12633
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee Brown's order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with two exceptions. The Determination Order was issued on March 15, 1991 rather than March 17, 1990. Also, we do not adopt the Referee's ultimate finding of fact (number 2) that claimant's worsening is not greater than the waxing and waning of symptoms contemplated by the award.

CONCLUSIONS OF LAW AND OPINION

In order to prove a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396, 401 (1986). Finally, because claimant received a previous permanent disability award for her condition, she must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

The Referee concluded that claimant had established a symptomatic worsening of her condition, but had failed to establish that the worsening was more than a waxing and waning of symptoms contemplated by the March 15, 1991 Determination Order that awarded 17 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the left foot. We disagree that the Determination Order anticipated future waxing and waning of claimant's symptoms. ORS 656.273(8).

Although there was no medical evidence in existence at the time of the last award of compensation (the March 15, 1991 Determination Order) that predicted future waxing and waning of the low back condition, the Referee "related back" January 1992 statements from Dr. McCullough, the attending physician. Dr. McCullough had anticipated that claimant's experiences of pain would fluctuate depending on her activity level (Ex. 42-32), and had told claimant she could anticipate days when she had more pain and less pain. (Ex. 42-21). The Referee concluded that the "evaluator took that into consideration when she allowed an award for adaptability."

On review, claimant argues there was no evidence in existence at the time of claim closure predicting a flare-up of her condition. Therefore, claimant contends that the last award of compensation did not contemplate such periods of waxing and waning. We agree.

When there is 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, 106 Or App 687, 690, rev den 312 Or 150 (1991). Here, there is no evidence of any predictions of future flare-ups prior to the March 15, 1991 Determination Order that awarded claimant 17 percent unscheduled permanent disability. There is no indication that the Determination Order award was based on a chronic condition. (Ex. 30). See Theodore W. Kinder, 46 Van Natta 391, 393 (1994). Rather, according to the Evaluator's Worksheet, the award was based on claimant's surgery and reduced range of motion.

Since Dr. McCullough's January 1992 observations were offered some 10 months after the March 1991 Determination Order, those statements could not support a conclusion that the last award of compensation anticipated future waxing and waning symptoms. In other words, when the Determination Order awarded permanent disability, such statements were not in existence. Instead, the medical evidence in existence at the time of the last award of compensation does not support a finding that the Determination Order "contemplated" future waxing and waning of the low back condition. See Debra K. Donovan, 45 Van Natta 1175, 1176-77 (1993); Linda J. Hughes-Smith, 45 Van Natta 827, 828 (1993).

In any event, Dr. McCullough testified that the increased physical demands of claimant's job were not anticipated in March 1991. (Ex. 42-33). Consequently, even if we considered the Determination Order to have contemplated future waxing and waning of symptoms, we would conclude that claimant's current symptoms exceed those symptoms anticipated by that award. Because we conclude that the last award of compensation did not contemplate future waxing and waning of the compensable condition, we address the other elements necessary to establish an aggravation.

The self-insured employer contends that there are no reliable objective findings that claimant's condition worsened. The employer argues that Dr. McCullough anticipated repeated spasmatic periods at the time of the last award of compensation and that he inappropriately relied on claimant's subjective complaints of pain because her subjective responses are not reliable. We disagree.

Objective findings of a worsened condition may be based on a physician's evaluation of the worker's description of the pain that she is experiencing. Stanley Smith Security v. Pace, 118 Or App 602, 605, rev den 317 Or 272 (1993); Georgia-Pacific Corp. v. Ferrer, 114 Or App 471, 474 (1992). Dr. McCullough said that when he saw claimant on September 18, 1991, she "seemed genuinely, significantly more uncomfortable." He said there was a difference in her condition and that claimant had "destabilized." (Ex. 41-23). Moreover, he found objective changes in her condition, including altered deep tendon reflexes and increased muscle tone. Because Dr. McCullough treated claimant at the time of the last award of compensation and continued to treat her through the date of the later condition, he was in the best position to evaluate the reliability of her complaints. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Therefore, we find Dr. McCullough's observations to be persuasive.

The employer accurately notes that Dr. McCullough said that claimant remained medically stationary in September 1991. (Ex. 38A). Although Dr. McCullough made that statement, he later clarified that opinion. Specifically, he explained that after gaining a better understanding of the legal definition of "medically stationary," he concluded that claimant was "medically not stationary" at that time. (Ex. 42-26). In light of this explanation, as well as Dr. McCullough's familiarity with claimant's condition and her complaints, we find no persuasive reason not to rely on Dr. McCullough's opinion. We agree with the Referee that claimant has established a symptomatic worsening of her condition.

Finally, we hold that claimant has established that her worsened condition resulted in diminished earning capacity as compared to the date of the last award of compensation. Dr. McCullough ordered three days of bed rest as a result of claimant's condition, which temporarily decreased her earning capacity. Based on this record, we conclude that claimant has established a compensable aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated August 10, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the employer.

May 26, 1994 Cite as 46 Van Natta 1028 (1994)

In the Matter of the Compensation of
MARGIE J. GARCIA, Claimant
WCB Case No. 92-03505
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Claimant requests reconsideration of that portion of our February 9, 1994 Order on Review which affirmed and adopted the Referee's February 16, 1993 order finding that claimant was not permanently and totally disabled. Specifically, claimant contends that her preexisting conditions were at least partially disabling at the time of her compensable injury. Therefore, claimant contends that those conditions should be considered in determining whether claimant is permanently and totally disabled. Claimant also contends that the Referee applied the wrong legal standard in determining whether she is permanently and totally disabled.

On March 9, 1994, we withdrew our February 9, 1994 order for reconsideration. The insurer's response to claimant's motion has been received. Accordingly, we proceed with our reconsideration.

Claimant contends that preexisting conditions need not be totally disabling in order to be considered in the evaluation of permanent and total disability. She asserts that her preexisting conditions were at least partially disabling at the time of her compensable back injury in November 1989. Specifically, claimant points out that she required treatment for chronic headaches prior to her injury, and that she suffered from long-standing psychological problems. (See Exs. 2, 2A-1, 2B, 3, 3D, 7-1, 7-2; 64-8 to -11, 64-15). She also suffered from chest pain prior to her injury. (Ex. 4-2).

Preexisting disability is to be considered in determining whether a worker is permanently and totally disabled. ORS 656.206(1)(a). In Elder v. Rosboro Lumber Co., 106 Or App 16, 19 (1991), the court explained:

> "[T]he statute refers to preexisting disability, not preexisting condition. The disabling effects, if any, of claimant's ... condition that preexisted the injury must be taken into account in determining whether he is permanently and totally disabled. However, any disability that developed as a result of the condition after the injury, but not as a result of the employment, may not be considered." (Citation Omitted) (Emphasis in original).

In Elder, the court rejected the claimant's argument that a preexisting condition which is symptomatic, but not disabling, prior to the compensable injury constitutes a preexisting disability, and that any post-injury increase in disability resulting from a worsening of that condition should be considered in evaluating permanent and total disability. Id. at 18.

In other words, we are required to consider claimant's disability resulting from a preexisting condition as the disability existed at the time of the injury. See Donald L. Savage, 39 Van Natta 758, 760 (1987). Disability from a preexisting condition need not be total to be considered; however, we consider only that disability which existed prior to the compensable injury. A noncompensable disability that occurs after a work injury, which did not exist at the time of that injury, is not considered in determining the extent of permanent disability. Searles v. Johnston Cement, 101 Or App 589, 592-93 (1990), rev den 310 Or 393 (1990).

"Disability" is defined as "the inability to pursue an occupation because of mental or physical impairment." Webster's New Collegiate Dictionary (1981). As Professor Larson explains, the "disability" concept in the workers' compensation context is a blend of two components: (1) disability in the medical or physical sense; and (2) the inability to earn wages. 2 Larson §57.11. Thus, in determining whether claimant was disabled due to her preexisting conditions, we consider medical or physical disability and the extent to which claimant was unable to work. See Curt O. Teeter, 46 Van Natta 160 (1994) (claimant's preexisting alcoholism did not prevent him from working at the time of his compensable injury).[1]

Here, we find little evidence that claimant's preexisting conditions interfered with her ability to work prior to her compensable injury. Although she required treatment for her preexisting conditions, she only occasionally missed work due to illness from headaches, kidney stones, or colitis. (See Tr. 24-27). Thus, we do not find that these medical conditions were disabling at the time of claimant's 1989 compensable injury.

Moreover, to the extent such evidence arguably establishes "partial disability" at the time of injury, the "disability" was minimal, and we would consider it only to that minimal extent. In other words, we would consider her preexisting disability in determining whether claimant is permanently and totally disabled, but only to the extent that disability existed at the time of the compensable injury (i.e., claimant occasionally missed work due to headaches, colitis or kidney stones).

Regarding claimant's psychological condition, we find no evidence that her preexisting psychological condition interfered with her ability to work at the time of the compensable injury. Dr. Parvaresh, examining psychiatrist, testified that psychological problems like claimant's can interfere with the ability to work, but he did not opine that claimant's psychological condition had, in fact, interfered with her ability to work prior to her compensable injury. (See Ex. 64-13 to -14). He further stated that claimant's psychological condition in 1992 did not prohibit her from working. Specifically, he opined that "her psychological condition is no different now [September 1992] than it was in 1988 and if she was able to work then, she should be able to do so now." (Ex. 61-11). In addition, claimant testified that she received no treatment for her psychological condition prior to her work injury. (Tr. 77; Exs. 61-6, 64-7). Accordingly, we conclude that claimant's preexisting psychological condition was not disabling at the time of the compensable injury.

The dissent relies on Dr. Parvaresh's opinion, but concludes that claimant's psychological condition was at least partially disabling at the time of her 1989 compensable injury. In doing so, the

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[1] As claimant Teeter's former attorney, Board Member Hall did not participate in the Board's review of this case.

dissent ignores the evidence, including Dr. Parvaresh's testimony, that indicates claimant was functioning successfully at the time of her compensable injury, despite the existence of longstanding psychological problems. Furthermore, we disagree that Dr. Parvaresh's testimony establishes that claimant's preexisting psychological condition, in fact, had a limiting effect on her employability. Dr. Parvaresh discussed the disabling effects of claimant's preexisting psychological condition in general and hypothetical terms, stating only that psychological problems like claimant's can interfere with the ability to work. He did not opine that claimant's psychological condition had, in fact, interfered with her ability to work at the time of the compensable injury. In light of the evidence that indicates claimant was functioning successfully at work at the time of her injury, we disagree that Dr. Parvaresh's opinion establishes that claimant's psychological condition was even partially disabling prior to the injury.

Furthermore, the dissent's analysis blurs the distinction between preexisting conditions and preexisting disability. In analyzing preexisting conditions, the dissent focuses on whether those conditions had any disabling effects. Yet, when factoring preexisting disability into the evaluation of permanent total disability, the dissent then focuses on preexisting conditions. It is only the preexisting disabling effects that are factored into the permanent total disability analysis, not the condition itself. See Elder v. Rosboro Lumber Co., supra. Here, although claimant's preexisting psychological condition may not have changed, its disabling effects clearly increased after claimant's 1989 compensable injury. It is that subsequent level of disability that the dissent finds contributes to claimant's permanent total disability, yet that level of disability developed only after the compensable injury and cannot be considered.

Because we have concluded that claimant's preexisting conditions were not disabling at the time of the compensable injury, we continue to find that the Referee did not err in excluding claimant's preexisting conditions in evaluating permanent total disability.

Claimant also contends that the Referee applied the wrong legal standard by requiring her to prove that her compensable back injury "played a material and meaningful role" in her inability to work. (Opinion and Order at 6). We disagree.

The compensable injury must be at least a material contributing cause of claimant's disability. See Weyerhaeuser Company v. Rees, 85 Or App 325, 328-29 (1987). We do not understand the Referee's language to impose a standard any higher than "material contributing cause." At most, we find that the term "meaningful" as used by the Referee is simply explanatory of the term "material." Therefore, we conclude that the Referee did not apply the wrong legal standard with respect to determining whether claimant is permanently and totally disabled.

However, on the merits, we disagree with the Referee's determination that the compensable back condition was not even a material contributing cause of claimant's disability. Claimant continued to complain of back pain, and she was treated for chronic lumbar strain, even after she became medically stationary from the back injury. She complained of low back pain when she attempted to return to work, and she ultimately left work, in part, due to her compensable injury. The Referee awarded 29 percent unscheduled permanent disability, and neither party contends that claimant is not entitled to at least permanent partial disability for her back condition. Thus, we conclude that the compensable back condition was at least a material contributing cause of claimant's disability.

Nevertheless, we agree with the Referee's determination that claimant is not permanently and totally disabled on a medical basis alone. In this regard, as discussed above, we do not consider claimant's preexisting conditions, because we have found that they were not disabling at the time of the compensable injury. We would reach the same conclusion were we to consider claimant partially disabled by preexisting conditions, because we must consider the disability as it existed at the time of the compensable injury.

Inasmuch as claimant has not argued that she is permanently and totally disabled under the "odd lot" theory, we decline to expand upon the Referee's discussion of this issue. We continue to adopt and affirm the Referee's determination that claimant is not permanently and totally disabled under the "odd lot" theory.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 9, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Hall dissenting.

Because I believe claimant has proven that she is permanently and totally disabled, I respectfully dissent.

I disagree with the majority's conclusion that claimant had no preexisting disability at the time of her compensable back injury in November 1989. The majority acknowledges that claimant missed work (pre-injury) due to colitis, kidney stones and chronic headaches. Yet, the majority then concludes that these conditions were not disabling. Claimant also had a preexisting psychological condition, which I find was at least partially disabling at the time of the compensable injury.

Based on a finding that claimant's preexisting conditions interfered, at least to some extent, with her ability to pursue employment, I would find that these preexisting conditions were at least partially disabling at the time of the compensable injury. To the extent these preexisting conditions had an effect on claimant's ability to compete in the labor market before the compensable injury, they must be factored into the evaluation of permanent and total disability.

The testimony of examining psychiatrist, Dr. Parvaresh, establishes that claimant's preexisting psychological problems had a limiting effect on her employability at the time of her compensable injury. Claimant's psychological makeup was such that it would restrict her ability to compete in the work force, because claimant would be unable to function in certain types of jobs. (See Ex. 64 at 8-14). It is not necessary for claimant to prove that she required psychological treatment, or that she was completely unable to work due to her psychological condition, in order to establish that her psychological condition was (at least partially) disabling at the time of the compensable injury. See Weyerhaeuser Company v. Rees, 85 Or App 325 (1987); Leroy E. Jones, 43 Van Natta 1492 (1991).

Claimant need not prove that she suffered an obvious or blatant preexisting loss, such as the loss of a limb, in order to establish a preexisting disability. It is sufficient to prove that a preexisting condition had disabling effects; i.e., that the condition interfered to some extent with claimant's ability to pursue an occupation. See Elder v. Rosboro Lumber Co., supra. Here, the preexisting effect on claimant's employability may have been subtle, but it was still real.

Furthermore, the medical evidence establishes that claimant's psychological condition did not worsen subsequent to the compensable injury. Dr. Parvaresh identifies claimant's primary psychological condition as being a personality disorder, a condition which remains relatively unchanged over time. (Ex. 64-10). Dr. Parvaresh opined that claimant's psychological condition in 1992 was no different than it was at or prior to the time of her 1989 work injury. (Ex. 61-11). Thus, I would conclude that claimant's preexisting disability due to her psychological condition, which remained unchanged after the compensable injury, must be considered in determining whether claimant is permanently and totally disabled.

When claimant's preexisting disabilties, due to her preexisting physical conditions as well as her preexisting psychological condition, are combined with the disability due to her compensable injury, and when the non-medical "odd-lot" factors are also considered, I believe claimant has established that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). I would find that claimant is permanently and totally disabled.

In the Matter of the Compensation of
HUBERT R. GRAVES, Claimant
WCB Case No. 93-04618
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Referee Baker's order that set aside its partial denial of claimant's injury claim for a right shoulder/arm condition. Claimant cross-requests review of that portion of the Referee's order that declined to assess a penalty for the insurer's allegedly untimely claim processing. In addition, claimant moves to supplement the record or, alternatively, to remand for admission of post-hearing surgical reports, which he submits on review. On review, the issues are evidence (remand), compensability, and penalties. We deny claimant's motion, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the Referee's order concerning the merits of the injury claim. See ORS 656.005(7)(a).

Evidence (Remand)

Claimant moves to supplement the record or, alternatively, to remand for admission of post-hearing surgical reports, which he submits on review. The insurer opposes claimant's motion, arguing that the reports were obtainable with due diligence at hearing.

We treat the motion to supplement the record as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985). In this regard, we first note that we have no authority to consider any evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the post-hearing 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 Cain v. Woolley Enterprises, 301 Or 650, 654 (1986) (citing Compton v. Weyerhaeuser Co., 301 Or 641 (1986). We consider the disputed evidence only for the purpose of determining whether remand is appropriate.

The evidence submitted for the first time on review arises out of claimant's right shoulder surgery, which was performed after the record was closed. Under these circumstances, we find that the disputed evidence concerns claimant's disability. In addition, we find that it was not obtainable at the time of hearing. However, claimant prevailed at hearing concerning the compensability of his right shoulder condition and we uphold the Referee's decision, without the benefit of the treating surgeon's post-hearing reports. Under these circumstances, we further find that the post-hearing reports are not reasonably likely to affect the outcome of the case. Accordingly, claimant's motion to remand is denied. Compare Parmer v. Plaid Pantry # 54, 76 Or App 405, 409 (1985) (Where the proferred evidence concerning claimant's post-hearing surgery "vindicated" the treating physician's prior opinion that the work injury was merely a possible cause of claimant's need for treatment, the Board abused its discretion by not remanding the case to the referee).

Penalty

Claimant requests a penalty based on the insurer's allegedly untimely processing of his claim for right shoulder problems. (Tr. 4-6). In support, claimant relies on evidence that the insurer was aware

of his shoulder complaints in November 1992 (see Ex. 10), or sometime before February 8, 1993 at the latest (see Ex. 15). The partial denial of claimant's upper extremity complaints issued on April 2, 1993. (Ex. 21). Thus, according to claimant, the insurer did not respond to the claim for shoulder/arm problems within 90 days, as required by ORS 656.262(6).

The insurer responds that no claim was filed for the right shoulder until February 8, 1993, when it first received notice that claimant's right shoulder problems might be related to the work injury. (See Ex. 15). Thus, according to the insurer, claimant has not established that the April 2, 1993 denial issued more than 90 days following notice of the claim.

We agree with claimant that Dr. Thayer's January 27, 1993 letter appears to respond in part to questions posed by the insurer regarding claimant's shoulder condition. That suggests to us, as it did to claimant, that the insurer had notice of the shoulder condition sometime before Dr. Thayer responded to those questions. However, because no claim[1] for a right shoulder condition was filed until February 8, 1993 (see Ex. 15), we conclude that the insurer's April 2, 1993 partial denial was timely. Accordingly, no penalty is assessed on this basis.

Finally, we note that the Referee found no unreasonable conduct in processing the claim and denied claimant's request for a penalty based on such unreasonable conduct. (O&O pp. 4-5). Because claimant sought a penalty only for untimely processing (not unreasonable processing), we modify the order to clarify the basis for the penalty requested.

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

ORDER

The Referee's order dated August 20, 1993 is modified in part and affirmed in part. That portion of the order that denied claimant's request for a penalty is modified to reflect that the penalty is requested based on allegedly untimely processing of the claim for a right shoulder/arm condition. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded a $1,000 attorney fee, payable by the insurer.

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[1] "'Claim' means a written request for compensation . . . or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). An insurer is not obligated to accept or deny a claim until it has notice or knowledge prompting a reasonable belief that workers' compensation liability is a possibility. See ORS 656.262(6); William H. Waugh, 45 Van Natta 919 (1993).

In this case, the first mention of shoulder symptoms after the compensable injury is found in a November 13, 1992 chartnote by Dr. Thayer, treating physician. (Ex. 10). The note describes right shoulder x-ray findings (calcific tendinitis and probable AC joint narrowing) without implicating the May 22, 1992 compensable right hand injury. Although claimant did receive physical therapy treatments for his right shoulder in 1992 --about 6 months after the work accident (Ex. 11a-1), we find that the insurer first received notice that claimant's right shoulder problems were claimed to be related to the work injury on February 8, 1993. On this date, the insurer received Dr. Thayer's January 27, 1993 letter stating "there is no doubt that my treatment of [claimant] on 11/13/92 and 11/20/92 was for an acute painful process in his shoulder with an ongoing painful hand and would be directly related to the original industrial injury." (Ex. 15-2).

In the Matter of the Compensation of
KIM J. HAYES, Claimant
WCB Case No. 93-00798
And, In the Matter of the Compensation of
PAULA O. ZENOR, Claimant
WCB Case No. 92-14987
And, In the Matter of the Complying Status of
TWO D'S TRUCKING, INC., Employer
WCB Case No. 92-12689
ORDER ON REVIEW
James B. Griswold, Claimant Attorney
Malagon, et al., Defense Attorneys
William J. Blitz, Defense Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Two D's Trucking, Inc., an alleged noncomplying employer, requests review of those portions of Referee Livesley's order that: (1) found Kim J. Hayes and Paula Zenor to be subject workers for Two D's Trucking; (2) affirmed The Proposed and Final Order Declaring Noncompliance and Assessing a Civil Penalty; and (3) found that the SAIF Corporation, on behalf of Two D's Trucking, was responsible for the processing of Kim J. Hayes' and Paula Zenor's claims. On review, the issues are subjectivity and noncompliance.

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

Two D's Trucking contends that the Referee erred in denying its motion to join other alleged employers of the claimants pursuant to ORS 656.740. We disagree.

ORS 656.740(2) provides that an insurance carrier may be joined if it is alleged by the noncomplying employer that the carrier provided workers' compensation coverage for the alleged noncomplying employer during the time period in question. It does not provide for the joinder of other alleged employers of the subject workers in question. Accordingly, ORS 656.740 does not provide a basis for the joinder which Two D's Trucking seeks. In addition, four of the five employers that Two D's Trucking seeks to join are out-of-state employers. Two D's Trucking has provided no authority, and we have found none, that would allow an out-of-state employer to be joined in a workers' compensation proceeding.

Claimant Hayes is entitled to an assessed attorney fee for prevailing over Two D's Trucking'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 Hayes' attorney's services on review is $2,000, to be paid by the SAIF Corporation on behalf of Two D's Trucking. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant Hayes' respondent's brief), the complexity of the issues, and the value of the interest involved.

In addition, claimant Zenor is entitled to an assessed attorney fee for prevailing over Two D's Trucking'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 Zenor's attorney's services on review is $1,700, to be paid by the SAIF Corporation on behalf of Two D's Trucking. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant Zenor's counsel's statement of services and respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 25, 1993, as reconsidered September 17, 1993, is affirmed. For services on review, claimant Hayes' attorney is awarded an assessed attorney fee of $2,000, payable by the SAIF Corporation on behalf of Two D's Trucking. For services on review, claimant Zenor's attorney is awarded an assessed attorney fee of $1,700, payable by the SAIF Corporation on behalf of Two D's Trucking.

In the Matter of the Compensation of
JOHN R. JOHANSON, Claimant
WCB Case No. 93-10812
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On May 17, 1994, we dismissed the self-insured employer's request for Board review. In reaching this conclusion, we presumed that the employer's request (which was not mailed by certified mail and was actually received by the Board more than 30 days from the Referee's March 18, 1994 order) was untimely. See OAR 438-05-046(1)(b). However, noting that this presumption was rebuttable, we advised the employer that we were willing to reconsider our decision provided that the employer could establish that its request for review was timely mailed to the Board.

In response to our dismissal order, the employer has submitted several affidavits from its legal counsel and counsel's employees which attest that the employer's original request for review of the Referee's March 18, 1994 order was mailed to the Board on April 1, 1994. Relying on these sworn representations, the employer seeks reconsideration of our dismissal order and reinstatement of its appeal.

In order to further consider this matter, we withdraw our May 17, 1994 order. The other participants to this proceeding are granted an opportunity to respond. To be considered, such responses must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. KENDALL, Claimant
WCB Case No. 92-05185
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Referee Tenenbaum's order that: (1) increased claimant's award of unscheduled permanent disability for a back injury from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees); and (2) set aside that portion of the Director's order under ORS 656.327(2) which found that claimant was not entitled to rehabilitative therapy after September 11, 1991. On review, the issues are extent of permanent disability and medical services. We reverse in part and affirm in part.

FINDINGS OF FACT

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

As of the date of the Order on Reconsideration, claimant was released to and had returned to his regular work as a tumbler operator.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The parties only contest the adaptability factor. Based on claimant's residual functional capacity as of the time of the Determination Order, the Referee concluded that claimant was entitled to an adaptability value of 3. The insurer contends that claimant's adaptability value is determined at the time of the Order on Reconsideration order rather than at the time of the Determination Order and therefore the Referee's adaptability value is incorrect.

Subsequent to the Referee's order, the court reversed our decision in Heather M. Smith, 44 Van Natta 2207 (1993), which held that adaptability was determined at the time of the Determination Order. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court held that a claimant's adaptability value was to be determined as of the date of the reconsideration order. Id.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the "standard" for evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of issuance of the Determination Order control the evaluation of permanent partial disability at hearing and on review of the reconsideration order. OAR 438-10-010(2) (WCD Admin. Order 2-1991; WCD Admin. Order 4-1991, temporary rule effective June 17, 1991).

At the time of the reconsideration order, claimant had been released to and returned to his regular work as a tumblecast operator. (Ex. 14, 17). Pursuant to former OAR 436-35-270(3)(c), a worker is not entitled to a value for adaptability if he or she has been released to regular work. Accordingly, claimant is not entitled to a value for adaptability.[1]

Pursuant to OAR 436-35-280(6) the adaptability value of zero (0) is multiplied by the values for age and education (4) for a total of zero (0). This value is added to the value for impairment (10) for a total of 10 percent unscheduled permanent disability. Inasmuch as the Order on Reconsideration awarded 10 percent unscheduled permanent disability, we modify the Referee's order and affirm the Order on Reconsideration's award.[2]

Medical Services

We adopt the Referee's conclusions and reasoning concerning rehabilitative therapy after September 11, 1991 with the following supplementation.

The insurer argues that the Referee erred in considering Exhibit 25 as it was not part of the record before the Director. If Exhibit 25 is not considered, the insurer contends that the Director's order is supported by substantial evidence and should be upheld. We disagree.

Subsequent to the Referee's order, we issued our decision in Julie Sturtevant, 45 Van Natta 2344 (1993). In Sturtevant, we held that review under ORS 656.327(2) of a Director's order was not limited to the record developed by the Director. Rather, based on the text and context of ORS 656.327(2), we concluded that the legislature intended referees to independently find facts based upon an evidentiary record developed at hearing. Sturtevant, supra at 2347.

Based on Sturtevant, the Referee in this case was not limited to the record developed before the Director and could admit Exhibit 25 into evidence. See also Ruby L. Goodman, 46 Van Natta 810, N.3 (1994).

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning the medical services issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's services on review is $250, 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.

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[1] In Michelle Cadigan, 46 Van Natta 307 (1994), we held that it was within the Director's statutory authority under ORS 656.726(3)(f)to promulgate "standards" which did not allow a value for adaptability where a worker had been released to regular work, returned to regular work, or had the residual functional capacity to perform regular work. Therefore, the "standards" applicable to this case, which give claimant a zero value for adaptability, are within the Director's authority pursuant to ORS 656.726.

[2] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Michelle Cadigan, supra, Member Hall directs the parties to his dissenting opinion in that decision.

ORDER

The Referee's order dated July 19, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that awarded an additional 12 percent (38.4 degrees) unscheduled permanent disability and an out-of-compensation attorney fee payable from this increased award is reversed. The Order on Reconsideration's award of 10 percent (32 degrees) unscheduled permanent disability is affirmed. The remainder of the Referee's order is affirmed. For services on review concerning the medical services issue claimant's counsel is awarded an assessed attorney fee of $250, payable by the insurer.

In the Matter of the Compensation of
RONNIE J. KISTLER, Claimant
WCB Case No. 93-08429
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a cervical condition. On review, the issue is aggravation.

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

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). A symptomatic worsening is sufficient to establish an aggravation. Debra K. Donovan, 45 Van Natta 1175, 1175 (1993).

Claimant was injured when a box fell on him at work on March 16, 1992. His injury was accepted as a "contusion, cervical spine." (Ex. 6-1). The claim was subsequently closed by a June 10, 1992 Determination Order without an award of permanent disability.

Claimant testified that at the time of closure he was experiencing mild symptoms of occasional headaches, upper back and arm pain. (Tr. 13). However, claimant's physicians noted no physical limitations. Claimant testified that these symptoms became increasingly more severe until he was compelled to seek medical treatment in October 1992. (Tr. 14).

On different occasions claimant was examined by Dr. Amodt (chiropractor), Dr. Poul (chiropractor) and Dr. Lee (M.D. specializing in physical medicine and rehabilitation). All these physicians agreed that, subsequent to claim closure, claimant was experiencing increased symptoms related to his March 1992 injury. (Exs. 13-1, 14-2, 14A-1, 21-3). Claimant was found to have decreased range of motion in his cervical area. (Exs. 12-2, 13-3. 15-4, 21-2). This loss of motion was also detected by Dr. Wilson, who examined claimant upon the request of SAIF. (Tr. 45-46, Ex. 15-4).

SAIF disputes the opinions of claimant's treating physicians (Drs. Poul, Amodt and Lee) and, instead, relies upon the medical opinion of two doctors who examined claimant at the request of SAIF: Drs. Wilson (neurologist) and Duff (orthopedist). (Ex. 15). Drs. Wilson and Duff examined claimant on July 7, 1993. They diagnosed claimant's condition as "mild contusion, right ear and neck, and possibly mild cervical strain, related to on-the-job injury of March 16, 1992, in the opinion of the undersigned resolved." (Ex. 15-5).

Drs. Wilson and Duff mentioned that claimant was experiencing muscle contraction neck pain and headaches, but they opine that those symptoms "are totally unrelated to the on-the-job injury of March 16, 1992." (Id.) They concluded that claimant was medically stationary without any worsening of his cervical spine contusion. (Id.).

SAIF argues that Drs. Wilson and Duff are more persuasive than claimant's three treating physicians. (App. Br. at 5). We find no compelling reasons to reject the opinions of the treating physicians. Drs. Poul and Amodt have treated claimant several times since the the date of injury, (Tr. 14), and are in a better position to gauge claimant's physical condition.

Moreover, Drs. Poul and Amodt substantiate their specific exceptions with the medical diagnoses rendered by Drs. Wilson and Duff. (e.g., failure to examine x-rays, (Ex. 3), taken of claimant subsequent to the injury; failure to discuss decreased range of motion in the cervical area; failure to discuss significance of their diagnosis of a possible cervical strain when the accepted condition was a contusion.) (Ex. 18). Therefore, there are no persuasive reasons to depart from the traditional deference given claimants' attending physicians. See Taylor v. SAIF, 75 Or App 583 (1985). We find their conclusion that claimant is experiencing a symptomatic worsening due to the March 16, 1992 injury to be persuasive.

SAIF argues, alternatively, that regardless of whether claimant has proven a symptomatic worsening of his condition, claimant failed to introduce any evidence of diminished earning capacity. (App. Br. at 6). We disagree.

Claimant and SAIF agree that claimant returned to regular work subsequent to his March 16, 1992 injury. (App. Br. at 5; Resp. Br. at 5). Dr. Poul submitted a "supplemental medical report" on August 8, 1993, wherein he released claimant to modified work with limitations on prolonged looking up, down and sitting. (Ex. 19). Dr. Lee opined that "if he can find a talk show host job that would be very appropriate job for his physical condition." (Ex. 21-3). In the absence of any contrary evidence, we conclude that claimant has established that his worsened condition has rendered him less able to work and has resulted in diminished earning capacity. Accordingly, we agree with the Referee that claimant has established a compensable aggravation.

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 issue of aggravation is $1,200, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's attorney's statement of service), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 2, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
THERESE L. PETKOVICH, Claimant
WCB Case No. 93-07299
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Galton's order that: (1) increased claimant's unscheduled permanent disability award for a neck condition from 18 percent (57.6 degrees), as awarded by Order on Reconsideration, to 24 percent (76.8 degrees); and (2) assessed a 25 percent penalty for the employer's allegedly unreasonable delay in paying compensation. On review, the issues are extent of unscheduled permanent disability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent

In calculating the extent of claimant's unscheduled permanent disability, the Referee applied the disability rating standards in WCD Admin. Order 93-052 (Temp.). Under those standards, the Referee assigned values for the non-impairment factors of age, education and adaptability. On review, the employer argues that the Referee's assignment of values for the non-impairment factors was in error because claimant's attending physician released her for regular work. We agree and reverse.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).[1] In this case, therefore, we apply the standards in WCD Admin. Order 6-1992, which were in effect at the time of the March 2, 1993 Notice of Closure.

Under those standards, claimant is not entitled to values for the non-impairment factors (age, education and adaptability) if she was released for regular work. See former OAR 436-35-290(2), 436-35-300(2), 436-35-310(2). Here, it is undisputed that claimant was released for regular work at the time of the determination.

However, the Referee concluded, and claimant argues on review, that application of the standards to assign no value for the non-impairment factors, based on a release for regular work, would conflict with the Supreme Court's decision in England v. Thunderbird, 315 Or 633 (1993), which held that the Director's standards were invalid under former ORS 656.214(5).

We rejected claimant's argument in Michelle Cadigan, supra. In Cadigan, we addressed England's applicability under the current version of ORS 656.214(5). Relying on the deletion of language from ORS 656.214(5) and the language of ORS 656.726(3)(f)(A), we found that permanent impairment only has to be "modified" by the factors of age, education and adaptability. In addition, we relied on legislative history indicating that the amendments to ORS 656.214(5) were made to give the Director the authority to define "earning capacity." We concluded that although the adaptability value may be zero, that is a modification contemplated by ORS 656.726(3)(f)(A). In light of the substantial change in the language of ORS 656.214(5) and the lack of contrary legislative history, we concluded that the applicable standards were within the Director's authority pursuant to ORS 656.726. Id.

Inasmuch as the standards we addressed in Cadigan are also applicable to this case, we conclude that those standards were within the Director's authority under ORS 656.726. Applying those standards, we assign no value for the factors of age, education and adaptability. We now proceed to the impairment factor.

The Referee assigned a total impairment value of 19, based on a combination of the surgery rating of 9 and the range of motion rating of 11. On review, the employer challenges only the range of motion rating of 11, contending that it should be reduced to 10. We agree.

Based on measurements of claimant's cervical range of motion in Exhibit 20, we find that extension is 46 degrees, flexion is 31 degrees, left lateral flexion is 30 degrees, right lateral flexion is 27 degrees, left rotation is 57 degrees and right rotation is 51 degrees. Based on those findings, we conclude that claimant's range of motion rating is 10. See former 436-35-360(3), (4), (5) and (6). Combining that rating with the surgery rating of 9, we find that the impairment value is 18. Accordingly, we conclude that claimant's unscheduled permanent disability award for her neck condition is 18 percent.

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[1] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Michelle Cadigan, supra, Member Hall directs the parties to his dissenting opinion in that decision.

Penalties

The Referee assessed a 25 percent penalty for the employer's late payment of compensation awarded by the Notice of Closure. It is undisputed that the employer was 23 days late in paying temporary total disability benefits and 7 days late in paying permanent partial disability benefits. On review, the employer argues that the penalty is excessive and that, under the Director's penalty matrix in Appendix B to WCD Admin. Order 1-1992, the penalty should be 5 percent. See OAR 436-60-155(6). We disagree.

We agree with and adopt the Referee's reasoning and conclusions regarding the penalty issue. Specifically, we agree with the Referee's conclusion that the penalty matrix is a guideline for the Director to use in assessing penalties. We find no language in OAR 436-60-155, and the employer points to none, which requires a referee or the Board to use the Director's penalty matrix.

Inasmuch as penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review for successfully defending the Referee's penalty assessment. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated October 13, 1993 is reversed in part and affirmed in part. Those portions of the order that modified the Order on Reconsideration to award claimant additional unscheduled permanent disability benefits and awarded claimant's attorney an out-of-compensation attorney fee are reversed. The Order on Reconsideration is affirmed without modification. The remainder of the order is affirmed.

May 26, 1994 Cite as 46 Van Natta 1040 (1994)

In the Matter of the Compensation of
MARK A. ROSENBLOOM, Claimant
WCB Case No. 92-08790
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee McCullough's order that found that the Hearings Division lacked jurisdiction over claimant's aggravation claim for a psychological condition (adjustment disorder) on the grounds that claimant's aggravation rights had expired. In its brief, the insurer contests that portion of the Referee's order that set aside its denial of claimant's claim for the psychological condition for which claimant has received medical services since April 1992. On review, the issues are jurisdiction, aggravation, and medical services. We reverse that portion of the Referee's order which held that the Hearings Division lacked jurisdiction over the aggravation claim; we uphold the insurer's aggravation denial; and we affirm that portion of the Referee's order that set aside the insurer's medical services denial.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the second full paragraph on page 3, with the following supplementation.

On February 12, 1986, the insurer accepted claimant's February 18, 1985 injury claim and classified it as nondisabling. Claimant's then attending physician authorized temporary partial disability on August 4, 1986. Claimant's claim was closed by Determination Order on May 20, 1987, with awards of temporary and permanent disability.

Dr. Parvaresh performed a psychiatric evaluation on August 30, 1990. He diagnosed a preexisting anxiety disorder, obsessive/compulsive traits and tendencies, and an adjustment disorder related to claimant's physical injury and its sequela. On September 13, 1990, the insurer accepted claimant's adjustment disorder as a consequence of the February 1985 injury. Claimant's claim was reclosed by Determination Order on April 16, 1991, with additional awards of temporary and permanent disability.

Since April 1992, claimant has been treated for an obsessive/compulsive disorder with symptoms of rumination and pre-occupation with physical health.

Claimant's condition was in "nondisabling status" for less than one year after claim acceptance.

Claimant's aggravation rights expired on May 20, 1992.

Claimant filed an aggravation claim on May 14, 1992.

Claimant's compensable adjustment disorder has not worsened since claim closure in April 1991.

The February 1985 injury is the major contributing cause of the obsessive/compulsive disorder for which claimant has received medical treatment since April 1992.

CONCLUSIONS OF LAW AND OPINION

Aggravation/Jurisdiction

The Referee found that claimant's "injury was nondisabling" for more than one year from the date of injury. Therefore, he applied ORS 656.273(4)(b) and held that claimant's aggravation rights began to run from the date of the February 1985 injury (rather than from the date of the first claim closure in May 1987) such that claimant's aggravation rights expired in February 1990. The Referee concluded, therefore, that the Hearings Division lacked jurisdiction to consider claimant's May 1992 aggravation claim. Citing DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993), claimant argues that because his claim was not accepted as nondisabling until one year after the injury, ORS 656.273(4)(a), rather than ORS 656.273(4)(b), applies. For the following reasons, we agree.

ORS 656.273(4) provides:

> "(a) The claim for aggravation must be filed within five years after the first determination order or the first notice of closure made under ORS 656.268.
>
> "(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

In DeGrauw, the court concluded that a claimant has one year from the date of injury in which to seek reconsideration of an insurer's decision to reclassify a claim from disabling to nondisabling. The court held that, if an insurer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of injury. Id.

Although the claimant in DeGrauw was challenging the insurer's reclassification of the claim from disabling to nondisabling, we have previously applied the reasoning in DeGrauw to the initial classification of claims. See Donald R. Dodgin, 45 Van Natta 1642 (1993) (finding the claimant's challenge to the insurer's initial nondisabling classification timely where the claimant's injury claim was not accepted until more than a year after the date of injury); Charles B. Tyler, 45 Van Natta 972 (1993) (finding the claimant's challenge to the insurer's initial nondisabling classification untimely where the claimant had four months to challenge the classification).

A claim is not deemed to be "in a nondisabling status" unless and until it is accepted and classified as nondisabling. Thomas L. Runft, 43 Van Natta 69 (1991). Thus, we must determine whether claimant's injury was in nondisabling status for more than one year after claim acceptance on

February 12, 1986. As claimant's condition became disabling on August 4, 1986, we find that it was not. Therefore, claimant's aggravation rights began to run from the date of the first claim closure in May 1987, and expired on May 20, 1992. ORS 656.273(4)(a); Dodgin, supra. Accordingly, we have jurisdiction over claimant's May 14, 1992 aggravation claim.

Because the Referee found that he did not have jurisdiction over claimant's aggravation claim, he did not address the merits. As the record is fully developed concerning this issue, we do so now.

Aggravation/Merits

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). If the requisite worsening is not established, claimant cannot have a compensable aggravation. Bertha M. Gray, 44 Van Natta 810 (1992), aff'd, Gray v. SAIF, 121 Or App 217 (1993).

In August 1990, Dr. Parvaresh, examining psychiatrist, diagnosed a preexisting anxiety disorder, obsessive/compulsive traits and tendencies, and an adjustment disorder related to claimant's physical injury and its sequela. Based on Dr. Parvaresh's report, the insurer accepted claimant's adjustment disorder. In May 1992, Dr. Takacs, claimant's attending osteopathic physician, advised the insurer that claimant was "doing worse psychologically."

In order to establish a compensable aggravation, claimant must, therefore, show that his accepted adjustment disorder worsened. The record contains the opinions of three psychiatrists: Dr. Farley, current treating psychiatrist; Dr. Larson, who treated claimant intermittently between 1975 and 1986 and reexamined claimant in February 1993; and Dr. Parvaresh, who examined claimant in 1990 and June 1992. Only Dr. Parvaresh has expressed an opinion regarding claimant's adjustment disorder. In a well-reasoned report, Dr. Parvaresh explained that claimant's compensable adjustment disorder has not worsened since 1990. There is no contrary opinion.

Consequently, claimant has failed to establish a compensable aggravation of his accepted adjustment disorder.

Compensability/Current Psychological Condition

The Referee found claimant's psychological condition for which he has received medical services since April 1992 compensable as a consequence of the 1985 injury. We adopt the Referee's conclusion on this issue, with the following comment.

Where a condition or need for treatment is caused by the compensable injury as opposed to the industrial accident, the 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, 113 Or App 411 (1992).

Here, claimant's attending physician and current and former treating psychiatrists have opined that claimant needs psychological counseling as a result of his physical disability due to the compensable injury. Inasmuch as claimant's psychological condition and need for treatment arose from the compensable injury rather than the industrial accident, claimant must establish that the injury is the major contributing cause of his current psychological condition and need for treatment. Albany General Hospital v. Gasperino, supra.

The insurer previously accepted claimant's adjustment disorder as a consequential condition. Thus, claimant's current psychological condition is compensable if claimant has required treatment for the accepted adjustment disorder or for any other psychological condition compensably related to the 1985 injury. We must ascertain, therefore, the condition for which claimant has received medical services since April 1992, and its cause.

Dr. Farley has treated claimant since mid-1992 for obsessive/compulsive behavior. Dr. Farley explained that claimant is over-focused on his physical health such that he is unable to deal with grief issues concerning his loss of body image and loss of self-esteem. Dr. Farley opines that claimant's obsessive/compulsive symptoms are "primarily from the orthopedic injury."

Dr. Larson, who first treated claimant prior to the 1985 industrial injury, reexamined claimant in February 1993. Dr. Larson also diagnosed an obsessive/compulsive trait disorder, characterized by excessive worry and rumination regarding health. Dr. Larson explained that claimant "experienced" the obsessive compulsive trait disorder "at the time of the injury." Further, Dr. Larson noted, preoccupation with his health prevents claimant from working in a productive manner.

The remaining psychiatric opinion is that of Dr. Parvaresh. Dr. Parvaresh initially examined claimant in August 1990, at which time he diagnosed a preexisting anxiety disorder, obsessive/compulsive traits and tendencies, and the compensable adjustment disorder. In June 1992, Dr. Parvaresh reexamined claimant. He observed that claimant is overly engrossed with various body functions. However, Dr. Parvaresh ascribed claimant's current psychological problems to his preexisting anxiety disorder. Dr. Parvaresh did not address Drs. Farley's and Larson's opinions that claimant's physical injury caused his obsessive/compulsive condition. Neither did he discuss the effects of claimant's obsession with health and fitness on his current mental functioning. Accordingly, we afford his opinion little weight on this issue.

Because we find the opinions of Drs. Farley and Larson persuasive, we conclude that claimant has established that the 1985 injury is the major contributing cause of his current psychological condition and need for treatment. Albany General Hospital v. Gasperino, supra. Consequently, claimant's current psychological condition and need for treatment are compensable.

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

ORDER

The Referee's order dated June 25, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that held that the Hearings Division lacked jurisdiction over claimant's aggravation claim is reversed. The insurer's denial of claimant's aggravation claim is upheld. The remainder of the Referee's order is affirmed. For services on review concerning the medical services issue, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

May 26, 1994 Cite as 46 Van Natta 1043 (1994)

In the Matter of the Compensation of
KATHY A. SCHALK, Claimant
WCB Case No. 91-18475
ORDER ON REVIEW (REMANDING)
Doblie & Associates, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Quillinan's order that: (1) found that claimant had unjustifiably delayed claimant's hearing concerning the SAIF Corporation's denial of her claim; and (2) dismissed claimant's hearing request pursuant to OAR 438-06-071(1). On review, the issue is dismissal. We reverse and remand.

FINDINGS OF FACT

We republish the relevant findings of fact from our previous order, Kathy A. Schalk, 45 Van Natta 1262 (1993), and supplement with additional facts.

Claimant filed a hearing request from SAIF's denial on December 30, 1991. A hearing was originally scheduled for March 24, 1992. On February 10, 1992, SAIF requested a postponement until claimant complied with SAIF's request to attend a medical examination (IME). Claimant attended the IME on March 11, 1992 and no postponement was granted. On March 23, 1992, the hearing was postponed because of claimant's inability to appear "due to medical reasons." The matter was then reset for hearing for August 3, 1992. It was again postponed on July 31, 1992 at the request of claimant's counsel, due to a scheduling conflict with another proceeding.

In March 1992, SAIF had served Dammasch State Hospital (Dammasch) with a subpoena duces tecum requesting claimant's hospital file. On March 26, 1992, Dammasch returned SAIF's subpoena, relating that it could not release information regarding claimant without her authorization.

On August 6, 1992, SAIF filed a motion for discovery, stating that it had asked claimant to sign a release authorization on April 14, 20, June 9 and August 6, 1992. On August 8, 1992, claimant signed the pertinent release. On August 20, 1992, Dammasch reported that it had no record of claimant's hospitalization in that facility.

On August 26, 1992, SAIF moved to dismiss claimant's hearing request, alleging that the first postponement of claimant's hearing was based on her alleged misrepresentation that she could not attend because of her in-patient hospitalization at Dammasch. SAIF, therefore, asserted that claimant had unjustifiably delayed her hearing, justifying the dismissal of her request for hearing.

On September 2, 1992, claimant responded to SAIF's motion to dismiss, asserting that SAIF's motion was based on allegation, rather than evidence. Claimant then requested an opportunity to respond to SAIF's allegations. In September 1992, the Referee dismissed claimant's hearing request, concluding there was an unjustified delay for over 60 days.

On previous review, we concluded the record was insufficient for us to determine whether claimant's delay in going forward with this proceeding was unjustified and we remanded for further proceedings. Kathy A. Schalk, supra. On remand, the Referee found there was no satisfactory explanation for claimant's failure to provide the medical release for more than 60 days and dismissed claimant's hearing request with prejudice.

CONCLUSIONS OF LAW AND OPINION

SAIF's original motion to dismiss claimant's hearing request alleged that the postponement of claimant's March 24, 1992 hearing was based on her alleged misrepresentation. On prior Board review, the parties focused on whether claimant had misrepresented the reason for her request for postponement of the hearing scheduled in March 1992.

SAIF now urges that "since postponement of the March 24, 1992 hearing is not at issue, the facts surrounding the postponement are not material." (Respondent's brief at 5). Instead, SAIF argues that the dismissal was warranted because claimant failed to provide the medical release to Dammasch for over 60 days without a reasonable explanation. We conclude that claimant's hearing request should not be dismissed because, whether or not claimant's signing of the release was timely, it did not result in a "delay in the hearing of more than 60 days." OAR 438-06-071(1).

The hearing was originally scheduled for March 24, 1992, but it was postponed because of claimant's inability to appear ("due to medical reasons"). Other than SAIF's initial allegation, the record does not establish that this postponement was granted due to claimant's failure to sign a release. In fact, this postponement preceded SAIF's request for claimant's execution of a release. Moreover, as represented by SAIF's brief on review, it no longer considers the facts surrounding the postponement to be material. In light of such circumstances, it cannot be found that the initial postponement of the hearing was attributable to any unjustified delay on claimant's part.

The hearing was reset for August 3, 1992. The record indicates that, on July 31, 1992, claimant's counsel requested and was granted a postponement because of a conflict with another proceeding. The record does not indicate whether the hearing was again reset. SAIF filed a motion for discovery on

August 6, 1992 and claimant signed the requested release authorization on August 8, 1992. SAIF moved to dismiss claimant's hearing request on August 26, 1992.

The Referee is authorized to dismiss a proceeding under OAR 438-06-071(1) only if "the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days." (Emphasis added). SAIF makes no argument that claimant abandoned her request for hearing.

On review, SAIF no longer argues about the propriety of the postponement of the March 24, 1992 hearing, which was reset to August 3, 1992. When claimant's attorney requested a postponement on July 31, 1992, SAIF made no objection. Because the second scheduled hearing was postponed again without objection on July 31, 1992 and SAIF no longer argues about the propriety of the first postponement, we conclude that the beginning date to calculate a "delay" in the hearing was July 31, 1992.

SAIF filed its motion for discovery on August 6, 1992 and claimant complied with the request on August 8, 1992. Therefore, assuming for the sake of argument that claimant's conduct constituted a "delay" in the hearing, that "delay" was only 8 days. OAR 438-06-071(1) does not authorize the Referee to dismiss claimant's request for hearing because the delay was less than 60 days. Cf. Shirley A. McCoy, 46 Van Natta 19 (1994) (insurer's motion to dismiss on the ground that the claimant had offered no medical evidence proving causation was not authorized under OAR 438-06-071).

For the foregoing reasons, we vacate the Referee's dismissal and reinstate claimant's hearing request.

ORDER

The Referee's order dated October 12, 1993 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to the Presiding Referee with instructions to assign this case to another Referee, who shall schedule and conduct a hearing in accordance with the Board's rules. Following completion of that hearing, the designated Referee shall issue a final, appealable order.

May 26, 1994 Cite as 46 Van Natta 1045 (1994)

In the Matter of the Compensation of
LUZ G. WIGANT, Claimant
WCB Case No. 93-01954
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Garaventa's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for an upper and lower 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 November 15, 1991, claimant compensably injured her back while assisting an aggressive patient. Her initial diagnosis was "posterior cervical and trapezius strain/TL paraspinous strain." Claimant continued with modified work until April 1, 1992 when she was released to regular work. Her claim was closed on April 15, 1992 with no award of permanent disability.

On November 10, 1992, claimant returned to Dr. Carney, treating physician, complaining of recurrent low back pain. (Ex. 4-8). A chartnote indicated that claimant experienced paraspinous spasm in the upper lumbar spine area with pain localizing to the right. (Ex. 4). A letter to the insurer stated that claimant had "re-aggravated" her November 1991 on-the-job injury. (Ex. 11). Dr. Carney referred claimant to Dr. Freeman, who reported that claimant was off work due to increased pain on November 18, 19 and 20, 1992. (Exs. 14, 16).

The Referee was not persuaded by Dr. Carney's opinion and concluded that claimant's condition had not worsened because there were "no true objective findings." We disagree.

The Referee based her conclusion that claimant's condition had not worsened on a November 17, 1992 medical arbiter's report from Dr. Fry stating that there were "no true objective findings that would indicate that [claimant] cannot do repetitive use of either her cervical, thoracic or lumbar spine." (Ex. 15). We note, however, that Dr. Fry's November 17, 1992 examination was obtained solely for the purpose of determining the extent of permanent disability. (Ex. 19). In fact, as noted above, the lack of objective findings specifically refers to ability to perform repetitive use of claimant's back. Furthermore, notwithstanding the fact that Dr. Fry observed considerable pain behavior throughout the examination, he reported tenderness to the right in the paravertebral musculature, involving the entire lumbar spine. (Ex. 15-3).

On April 5, 1993, Dr. Fry again examined claimant, on behalf of SAIF. As in his first report, Dr. Fry focused on disability, rather than providing an opinion concerning whether claimant had a worsening of her compensable injury.

On December 28, 1992, Dr. Carney stated that claimant suffered recurrent pain in her lower back that caused localized spasm. He stated that claimant had an exacerbation of her November 1991 injury which was a material contributing cause of her current condition. (Ex. 20).

Because Dr. Fry's conclusions after each of his examinations relate mainly to the extent of claimant's disability and do not address whether her compensable injury had worsened, we do not find his opinion persuasive with regard to the issue of aggravation. Rather, we are persuaded by Dr. Carney who, as treating physician, was in the best position to provide an opinion regarding the worsening of claimant's condition. See Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, because claimant was awarded no permanent disability, future exacerbations resulting in a loss of earning power were not contemplated. See Louis A. Duchene, 41 Van Natta 2399 (1989). Thus, any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity is sufficient to prove increased disability. Id. Accordingly, we conclude that claimant has met her burden of proving that she suffered a worsening of her November 1991 compensable injury which resulted in a diminished earning capacity.

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

ORDER

The Referee's order dated August 31, 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 Board review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by SAIF.

In the Matter of the Compensation of
SHARON WOLFE, Claimant
WCB Case No. 93-03124
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Galton's order that upheld the self-insured employer's denial of her medical services claim for a low back condition. In her appellant's brief, claimant also contends that the Referee erred in: (1) denying her motion to recuse the Referee; and (2) admitting Exhibit 12 and the testimonies of the employer's claims examiner and investigator. In addition, claimant has submitted an affidavit regarding the Referee's conduct prior to and during the hearing. We treat the submission as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). In its respondent's brief, the employer contends that the Referee erred in denying its motion to dismiss claimant's hearing request for allegedly causing an unjustified delay in the hearing. On review, the issues are dismissal, recusal, remand, evidence, and compensability. We deny the motion to dismiss and reverse on the merits.

FINDINGS OF FACT

Claimant has an accepted claim for a low back injury which occurred on February 1, 1990 while working as a radiologic technologist. Specifically, the employer accepted a lumbar strain/sprain and a herniated lumbar disc. The claim was closed by Determination Orders dated May 21, 1990, and February 8, 1991 with awards of temporary disability benefits only.

The claim was reopened again for an aggravation in July 1991. At that time, claimant was seeking treatment for low back pain radiating to the legs. Although surgery was considered, it was eventually rejected in favor of conservative treatment. Claimant has not worked since July 1991.

Claimant filed a claim for a psychiatric/psychological condition, including depression, headaches, sleeping difficulties and other physical manifestations aside from the accepted low back condition. The employer denied the claim, and claimant requested a hearing. By Disputed Claim Settlement dated January 15, 1992, the parties agreed to compromise and settle the denied claim for the psychiatric/psychological condition. The parties agreed that the denial shall be affirmed, and the hearing request dismissed with prejudice. (Ex. 7A).

On February 3, 1992, Travelers Insurance advised claimant that her claim for Long Term Disability benefits had been approved. Claimant began receiving Long Term Disability benefits of more than $1,400 per month. (Ex. 7B).

On February 21, 1992, the Board approved a Claim Disposition Agreement, whereby claimant agreed, in exchange for $20,000, to release her rights to all workers' compensation benefits, except medical services, for her accepted claim. (Ex. 8).

In October 1992, claimant saw osteopath Dr. Canzler for worsening back pain. He diagnosed probable spinal stenosis and referred claimant to Dr. Franks for a neurosurgical consultation. In November 1992 Dr. Franks ordered an MRI scan which he interpreted as showing mild disc bulging at L4-5 and L5-S1 and no evidence of stenosis. (Ex. 11). He recommended against surgery and referred claimant to neurosurgeon Dr. Ordonez for further consultation. Dr. Franks reported in his November 25, 1992 chart note that claimant "receives $1,400 a month from her insurance carrier." (Ex. 11).

Upon receipt of Dr. Franks' November 25, 1992 chart note, the employer's claims processor, which had not been paying benefits to claimant, assigned a field representative to investigate whether claimant was receiving benefits for an intervening injury from another carrier. At that time, the claims processor was not aware that claimant was receiving Long Term Disability benefits from Travelers.

The field representative, Gerald Wallis, telephoned claimant's attorney on or about January 15, 1993, to schedule claimant for a personal recorded statement. Claimant's attorney told Wallis that he would contact claimant and get back to Wallis. After several days without receiving a response, Wallis made several unsuccessful attempts to schedule the recorded statement through claimant's attorney's office. (Exs. 12A, 13A, 13B, 15).

On February 24, 1993, the employer issued a denial of claimant's then-current low back condition and resultant need for treatment, stating that the employer's "investigation was impeded by the refusal of [claimant's] attorney to allow a recorded statement on [claimant's] current activities and the possibility of an intervening injury." (Ex. 16). Claimant filed a hearing request from that denial. Subsequent to the denial, claimant's attorney refused to schedule claimant for a recorded statement. (Ex. 18A).

Travelers Insurance wrote claimant's attorney several letters requesting information concerning the status of her workers' compensation claim, but received no response. (Ex. 20).

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

At hearing, the employer moved for dismissal of claimant's hearing request under OAR 438-06-071(1), contending that claimant's refusal to make herself available for a recorded statement had resulted in an unjustified delay in the hearing of more than 60 days. We disagree.

OAR 438-06-071(1) provides that "[a] request for hearing may be dismissed if a referee finds that the party that requested the hearing. . .has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days."

Here, we are not persuaded that claimant caused any delay in the hearing. On the contrary, the hearing was held on the day it was scheduled. Pursuant to claimant's hearing request, the hearing was scheduled for June 3, 1993. On that date, both parties appeared with counsel and were prepared to proceed with the case. The employer cross-examined claimant under oath and, therefore, had the opportunity to obtain any information it had previously sought to obtain through a recorded statement. Had the employer been surprised by any of claimant's testimony, the employer could have moved for a continuance of the hearing.

In fact, the employer did move for a continuance at hearing, but then withdrew the motion. (Tr. 11-12). The employer later made another motion for continuance, which the Referee denied. (Tr. 115-16). On review, however, the employer does not challenge the Referee's denial of its motion. Under these circumstances, therefore, we do not find that claimant's conduct resulted in any delay in the hearing.

Medical Services

The Referee found that the medical services for claimant's low back complaints were noncompensable palliative care and, in any event, resulted entirely from her noncompensable psychological condition. On review, claimant argues that the medical services were diagnostic and curative and required for a worsened low back condition. We agree with claimant's contention and reverse the Referee's order.

For a compensable injury, a worker is entitled to "medical services for conditions resulting from the injury." ORS 656.245(1)(a). This entitlement extends to medical services for conditions which are directly caused in material part by the compensable injury. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). "Palliative care" means 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); Gladys M. Theodore, 46 Van Natta 318 (1994).

Here, the relevant medical opinions are from Drs. Canzler, Franks and Ordonez. Claimant saw Dr. Canzler with complaints of chronic, worsening back pain. Dr. Canzler diagnosed back pain which he suspected resulted from spinal stenosis. He referred claimant to Dr. Franks for a surgical consultation. (Ex. 9).

Dr. Franks ordered an MRI scan which revealed no evidence of spinal stenosis. He did not feel that surgery would be helpful, but he referred claimant to Dr. Ordonez "who apparently had given [claimant] some type of hope that he could take some pressure off nerve tissue and make her better." (Ex. 11).

Dr. Ordonez examined claimant, reviewed the MRI scan and diagnosed persistent low back pain secondary to a back strain at work and depression secondary to low back disability. (Ex. 13).

We find no persuasive medical evidence that relates claimant's low back complaints to a psychological condition. Although Dr. Ordonez diagnosed depression and prescribed a psychiatric consultation, he did not attribute claimant's low back pain to the depression, but rather, to the compensable back injury. (Ex. 13).

Further, although Dr. Canzler attributed claimant's complaints to spinal stenosis, his diagnosis was undercut by the subsequent MRI scan which revealed no evidence of stenosis. (Exs. 9, 11). Accordingly, we do not find Dr. Canzler's opinion to be persuasive.

Finally, we disagree with the Referee's reliance on Dr. Franks' opinion as a basis for upholding the denial. While Dr. Franks expressed doubt that claimant was totally disabled and that surgery would be helpful, he did not question the legitimacy of claimant's back pain and did not reach any final opinion concerning its cause. Hence, we view Dr. Franks' opinion as neither supporting nor denying a causal relationship between the back pain and the compensable injury.

We find, instead, that Dr. Ordonez's opinion is most persuasive. He directly attributed claimant's pain to the compensable back injury. He added that, "[d]epending on the results of the arthritis panel," he would consider a rheumatological consultation and facet joint injection. (Ex. 13). There are no subsequent medical reports in the record concerning claimant's condition or treatment.

Dr. Ordonez's opinion is consistent with claimant's uncontroverted testimony that her back condition has remained the same since the compensable injury and that she had not sustained any intervening back injuries. (Tr. 21-22, 24). Based on Dr. Ordonez's opinion and claimant's testimony, we find that the disputed medical services are intended to diagnose claimant's pain condition, and not to temporarily reduce or moderate the intensity of an otherwise stable medical condition. We also find that the compensable back injury was a direct and material cause of claimant's need for diagnostic services. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, supra; Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Kenneth M. Simons, 41 Van Natta 378, 380 (1989). Accordingly, we find that the medical services are compensable.[1]

Claimant is entitled to an assessed attorney fee for prevailing over the employer's medical services denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $1,500, to be paid by the employer. In reaching this conclusion, we have considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated June 25, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. Claimant's attorney is awarded $1,500 for services at hearing and on Board review, to be paid by the self-insured employer.

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[1] In the event that her claim was found compensable, claimant withdrew her objections to the Referee's denial of the recusal motion and her request for remand. Thus, as a result of our decision to set aside the employer's denial, we decline to address these procedural contentions. Nevertheless, our decision to do so should neither be interpreted as approval nor disapproval of the manner in which the hearing in this case was either heard or litigated. As with all proceedings convened before this forum, we assume that the conduct and behavior of each participant to such a proceeding (including the referee) is entirely professional and courteous.

In the Matter of the Compensation of
JANET R. CHAMP, Deceased, Claimant
WCB Case No. 93-03896
ORDER DENYING MOTION TO DISMISS
Max Rae, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

The self-insured employer has moved the Board for an order dismissing this request for Board review on the ground that the attorney for the deceased claimant does not have standing to request Board review. We deny the motion.

FINDINGS OF FACT

Claimant was compensably injured on August 3, 1991. The claim was closed by Determination Order. An Order on Reconsideration awarded claimant 7 percent (22.4 degrees) unscheduled permanent disability and 6 percent (9 degrees) scheduled permanent disability for the right leg (knee). Claimant timely requested a hearing seeking additional scheduled and unscheduled permanent disability compensation and penalties and attorney fees pursuant to ORS 656.268(4)(f) and (g).

Prior to hearing, the parties agreed to increase claimant's scheduled right leg award by 10 percent. On July 3, 1993, before a stipulation could be signed, claimant died. Claimant's daughter and the employer requested the Referee to establish whether the daughter was statutorily capable of executing a stipulation to finalize the agreement reached with claimant. The Referee's order issued April 5, 1994.

On April 19, 1994, the Board received a request for review of the Referee's order from the attorney for the deceased claimant.

On April 26, 1994, the Board received the employer's motion to dismiss the request for review on the ground that the attorney does not have standing to request Board review.

On May 2, 1994, the Board received a request for review from the attorney on behalf of the deceased claimant's daughter. That request was accompanied by an executed retainer agreement between the deceased claimant's daughter and her attorney.

CONCLUSIONS OF LAW AND OPINION

On April 19, 1994, claimant's attorney, on the deceased claimant's behalf, requested Board review of the Referee's April 5, 1994 Order. The employer moved that we dismiss the request for review because the attorney does not have standing to request Board review. We agree that the attorney had no standing to request review. See Raymond L. Rasmussen, 44 Van Natta 1704 (1992) (an attorney does not qualify as a "party" and, therefore, if no longer representing a "party," cannot request a hearing under ORS 656.283(1) or seek Board review under ORS 656.289(3)).

However, on April 28, 1994, the attorney, on behalf of the deceased claimant's putative beneficiary, her natural daughter, timely requested Board review. Survivor benefits are independent and not derivative of the injured worker's rights. See Fossum v. SAIF, 289 Or 787 (1980); Javier Mendoza, Dcd, 43 Van Natta 412 (1991). Inasmuch as a putative statutory beneficiary of a deceased worker (claimant's daughter) has requested Board review of the Referee's order within 30 days of its issuance, we conclude that we retain jurisdiction to consider this appeal.

Our decision should not be interpreted as a conclusion that the decedent's daughter is a statutory beneficiary for purposes of receiving compensation. Rather, our decision is merely designed to announce that the daughter has standing to bring the appeal for our resolution of the merits of her claim.

The employer, citing Trice v. Tektronix, Inc., 104 Or App 461 (1990), also argues that, because claimant's daughter is not a statutory beneficiary, she is not entitled to pursue her deceased mother's hearing request. Trice is distinguishable. In Trice, the court held that the right to pursue a deceased

claimant's hearing request is limited to statutory beneficiaries, a category that does not include the personal representative of a deceased claimant's estate. Here, the worker's daughter does not claim that she is a personal representative of claimant's estate. Rather, she claims to be a statutory beneficiary who is thereby entitled to recover benefits arising from the deceased worker's hearing request. We conclude that, in her capacity as an alleged beneficiary, the deceased claimant's daughter is entitled to seek Board review of the Referee's decision that she is not a statutory "beneficiary." Were we to do otherwise, we could be precluding this alleged beneficiary from obtaining review of a referee's order even though this alleged beneficiary has timely appealed that decision.

Accordingly, the motion to dismiss is denied. The briefing schedule shall be reimplemented as follows. The worker's putative beneficiary's appellant's brief has been received. Consequently, the employer's response is due 21 days from the date of this order. The appellant's reply brief is due 14 days from the date of mailing of the employer's brief. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

May 27, 1994 Cite as 46 Van Natta 1051 (1994)

In the Matter of the Compensation of
SCOTT PETTY, Claimant
WCB Case No. 93-05791
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Nichols' order which upheld the SAIF Corporation's denial of claimant's injury claim for a left knee and low back condition. During the briefing process, the employer has moved to strike claimant's appellant's brief due to claimant's failure to timely serve the employer with a copy of the brief. On review, the issues are compensability and motion to strike. We deny the motion and reverse.

FINDINGS OF FACT

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

Claimant had no knee or back problems prior to his compensable fall at work.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant timely submitted his appellant's brief to the Board and mailed a copy to SAIF. The employer, however, did not receive a copy of claimant's appellant's brief until only four days remained in which to respond. Thus, the employer claimed it was prejudiced by its failure to timely receive a copy of the brief. The employer requested an extension of time in which to file its respondent's brief and also moved to have claimant's appellant's brief stricken.

Although it is within the Board's discretion to strike a party's brief, we do not find that this is the appropriate remedy in this case. See David F. Weich, 39 Van Natta 468 (1987); James M. Kleffner, 38 Van Natta 1413 (1986). Here, the employer was granted its requested 17-day extension and has submitted a respondent's brief. Accordingly, the motion to strike claimant's appellant's brief is denied.

Compensability

Claimant sustained a compensable injury on February 16, 1993 when he slipped and rolled 20 feet down a mountainside while planting trees for the employer. SAIF accepted an abrasion to the left posterior thigh and a right knee contusion.

Claimant first saw his family physician, Dr. Christensen, on February 18, 1993. His complaints pertained to the right knee, right hip and left ankle. Dr. Christensen noted infrapatellar effusion in the right knee and diagnosed a sprained right knee and contusions. (Ex. 7). He referred claimant to Dr. Cronk, orthopedist, for the knee condition.

On March 1, 1993, Dr. Christensen referred claimant for an x-ray of his lower back, apparently because of sciatica and numbness in his right first and fifth toes. (See Exs. 8-1, 10). The x-ray showed a normal lumbosacral spine. (Ex. 5). An MRI of the low back on March 25, 1993, however, indicated a minor central disc herniation at L4-5. (Ex. 11).

On March 15, 1993, Dr. Cronk examined claimant, noting that claimant complained of swelling and pain in the right knee, and discomfort in the left knee. (Ex. 8). Dr. Cronk diagnosed recurrent post-traumatic effusions in the right knee, by history, which were currently negative. (Ex. 8-2).

On May 20, 1993, Dr. Cronk reported that claimant "still has pain and swelling in both knees." (Ex. 19). Dr. Cronk also referred claimant to his associate, Dr. Lewis, spinal surgeon, for continued low back pain. Dr. Lewis reported a normal back examination. However, he diagnosed a mechanical low back injury by history. (Ex. 20-2). Dr. Christensen reported that claimant's disc herniation was minor, and probably not responsible for any of claimant's symptomology. (Ex. 15-1).

In August 1993, claimant was examined by Dr. Neumann. He noted soreness in the left knee, and the right knee showed tenderness. (Ex. 26). Because of persistent symptoms, Dr. Neumann recommended an MRI study of claimant's knees.

SAIF denied claimant's claim for a left knee condition, stating that there were no objective findings. SAIF also limited its acceptance of claimant's right knee condition to a contusion. Finally, SAIF denied claimant's herniated disc at L4-5. Claimant requested a hearing.

The Referee concluded that, because the physicians who examined claimant found no objective findings relative to claimant's left knee and low back conditions, claimant had failed to prove that his February 16, 1993 injury was a material contributing cause of those conditions. We do not agree.

Under ORS 656.005(19), "objective findings" include "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." Furthermore, in Suzanne Robertson, 43 Van Natta 1505 (1991), we interpreted the "objective findings" requirement to be satisfied if a physician examines the worker and, based on that examination, finds that the worker suffers from a disability or a physical condition that requires medical services. Id at 1507.

We have also held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that his findings do not constitute objective findings is not relevant if those findings otherwise satisfy ORS 656.005(19). Craig H. Ayer, 43 Van Natta 2619 (1991), aff'd mem SAIF v. Ayer, 116 Or App 515 (1992); see Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992). In Ferrer, the court agreed with the Board's conclusion and analysis in Robertson, supra, that a claimant's unrebutted complaints of pain in specific areas and muscular responses during examination by the physician constituted objective findings. Georgia Pacific Corp. v. Ferrer, 114 Or App at 475.

In this case, Dr. Cronk examined claimant and, with respect to claimant's right and left knees, found bilateral crepitus on examination and diagnosed bilateral knee pain. (Ex. 10). Dr. Cronk also suggested that claimant change jobs because of the nature of his knee complaints. Dr. Christensen thought claimant may require arthroscopic surgery to discern the cause of the continued, intermittent knee pain and swelling.

With regard to claimant's back condition, Dr. Cronk referred claimant to Dr Lewis, back specialist, because of continuing back pain. (Ex. 19). Dr. Lewis reported that claimant's foot numbness had resolved, but that claimant continued to have pain in the middle of his low back, as well as to the right of the back. (Ex. 20-1).

The reports of Dr. Cronk and Dr. Christensen, as well as the reports of back pain by Dr. Lewis, constitute medical evidence supported by "objective findings." Notwithstanding the fact that the

physicians never witnessed the knee swelling, on the basis of their objective evaluations of claimant's complaints of left knee and low back pain, the physicians opined that claimant would have to change jobs and possibly undergo arthroscopic surgery of the knees. Such observations constitute medical evidence supported by "objective findings." ORS 656.005(19); Georgia Pacific Corp. v. Ferrer, supra.

Claimant must also establish that his February 1993 fall at work was a material contributing cause of his left knee and low back condition. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Based on our review of the record, we are persuaded that he has satisfied that requisite burden of proof.

After Dr. Christensen initially examined claimant, he referred claimant to Dr. Cronk for a consultation regarding claimant's knee complaints. Claimant reported to Dr. Cronk that when he fell he struck both knees and, although his right knee was his chief complaint, he had occasional mild pre-patellar discomfort in the left knee as well. (Ex. 8-1).

When Dr. Lewis examined claimant for continued back complaints, he diagnosed a mechanical low back injury by history. Dr. Lewis also agreed that the February 1993 fall was a "material contributing factor" to claimant's low back condition. (Ex. 24-2). Although Dr. Lewis' opinion is in the form of a "check-the-box" response, there are no opinions that relate claimant's complaints to anything other than his fall at work. Furthermore, each physician who examined claimant attributes his complaints to his fall.

Accordingly, after considering the opinions of all physicians who examined claimant, we are persuaded by the medical evidence that claimant's February 16, 1993 work injury was a material contributing cause of his left knee and low back condition.

At hearing, the employer introduced a video tape which shows claimant bending, lifting and twisting. It also shows claimant hammering and sawing, activities which claimant told an investigator he had not performed since his injury. However, even if claimant misrepresented his physical abilities, we do not consider such statements to be so profound as to cause us to reject the physicians' observations that claimant was experiencing complaints which were causally related to a fall at work (particularly when the record does not suggest an alternative reason for those complaints).

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

ORDER

The Referee's order dated August 18, 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 Board review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by SAIF.

In the Matter of the Compensation of
WILLIE A. SOWERS, Claimant
WCB Case No. 92-14414
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee T. Lavere Johnson's order affirming a Director's order under ORS 656.327(2) finding that claimant's fusion surgery at L4-S1 was inappropriate. Claimant moves the Board to remand the case to the Referee for further development of the record. We remand.

The Referee confined his review to the record developed before the Director. The Referee took this action in reliance on the Board's decision in Iola W. Payne-Carr, 45 Van Natta 335 (1993), aff'd Payne-Carr v. Oregon Portland Cement Company, 126 Or App 314 (1994).

Subsequent to the Referee's order, we issued our decision in Julie Sturtevant, 45 Van Natta 2344 (1993), in which we disavowed our holding in Payne-Carr. In Sturtevant, we reexamined the issue presented in Payne-Carr and concluded that, on the basis of the text and context of ORS 656.327(2), the legislature intended referees to find facts independently based on an evidentiary record developed at hearing. Id. at 2347.

We adhered to our rationale in Sturtevant in our recent decision in Ruby L. Goodman, 46 Van Natta 810, n.3 (1994). In Goodman, we acknowledged that the Court of Appeals affirmed Payne-Carr without opinion on February 19, 1994. Payne-Carr v. Oregon Portland Cement Company, supra. Nevertheless, we noted that the Board alternatively found in Payne-Carr that the result would have been the same if the Board considered the additional evidence offered by the claimant. 45 Van Natta at 337. We reasoned that the court's affirmance could have been based on either this alternative finding, or the Board's conclusion that referee review of a Director's order under ORS 656.327(2) is limited to the record developed before the Director.

Accordingly, because we do not interpret the court's affirmance of Payne-Carr as necessarily inconsistent with Sturtevant, we continue to follow Sturtevant. We, therefore, conclude that the Referee's review in the present case was improperly limited to the record developed before the Director. The parties were, instead, entitled to a hearing before the Referee, during which they could present evidence regarding the appropriateness of claimant's fusion surgery.

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

Here, there is a compelling reason to remand because the evidence at hearing was improperly limited to that developed before the Director. Ruby L. Goodman, supra. In particular, the Referee denied claimant's request to depose the doctors on whose opinions the Director relied in reaching his decision. (Tr. 4-5).

Accordingly, we remand this matter to Referee T. Lavere Johnson for further proceedings consistent with this order. These proceedings may be conducted in any manner that the Referee determines achieves substantial justice. At the further proceedings, the parties may present evidence regarding the propriety of claimant's fusion surgery. Thereafter, the Referee shall issue a final appealable order determining whether the Director's order was supported by substantial evidence in the record. ORS 656.327(2).

ORDER

The Referee's order dated May 26, 1993 is vacated. This matter is remanded to Referee T. Lavere Johnson for further action consistent with this order. The Referee may conduct these further proceedings in whatever manner the Referee determines achieves substantial justice.

In the Matter of the Compensation of
FLOARE TAUT, Claimant
WCB Case No. 91-12790
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, who speaks little if any English, was off work from about November 21, 1990 to April 5, 1991 as the result of a low back injury unrelated to this claim. (Tr. 20, Ex. A). On November 27, 1990, she was treated by Dr. Setera, chiropractor, who noted a complaint of wrist swelling. (Ex. 0).

On April 5, 1991, claimant returned to modified work, which consisted of polishing marble, dusting, wiping furniture and polishing brass for four hours a day, five days a week. (Ex. D).

On August 5, 1991, claimant sought treatment for sharp pains in both wrists that arose while she was scrubbing brass. (Ex. 1). Dr. Rabie diagnosed bilateral wrist tendinitis overuse syndrome. (Ex. 2-5).

On August 23, 1991, the insurer denied claimant's bilateral wrist tendinitis as unrelated to her work. (Ex. 8).

On August 26, 1991, claimant reported nocturnal paresthesia. Dr. Rabie found tenderness in the wrists, which caused him to recommend nerve conduction studies to rule out carpal tunnel syndrome. He further modified claimant's work to exclude scrubbing, polishing, buffing or vacuuming. (Ex. 9-2). Nerve conduction studies were normal. (Ex. 11-1).

On October 1, 1991, Drs. Belleville, psychiatrist, Fuller, orthopedic surgeon, and Brooks, neurologist, examined claimant for the insurer. (Exs. 13 and 14).

On October 18, 1991, claimant sought treatment from Dr. Brett, who had treated her low back. He diagnosed work-related acute bilateral carpal tunnel syndrome. (Exs. 17, 21 and 22).

On November 8, 1991, Dr. Button examined claimant and reviewed her medical records. (Ex. 19).

On January 23, 1992, Dr. Brett performed a carpal tunnel release on the right wrist and on February 2, 1992, he performed the same surgery on the left wrist. (Exs. 25 and 26).

Claimant has functional overlay. (Exs. 13, 14, 19, 20, App. Brief at 3).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her bilateral wrist condition is compensable. The insurer contends that claimant's functional overlay is so severe that it renders her subjective pain complaints unreliable and that the normal nerve conduction studies are irreconcilable with a diagnosis of carpal tunnel syndrome. We disagree with the insurer and find claimant's condition compensable.

Claimant has the burden of proving, by medical evidence supported by objective findings, that her work exposure, including any series of traumatic events or occurrences which require medical services or result in disability, was the major contributing cause of her bilateral wrist condition, diagnosed as carpal tunnel syndrome. ORS 656.802(1) and (2).

Here, Dr. Brett, claimant's treating neurosurgeon, diagnosed bilateral carpal tunnel syndrome. He later performed bilateral carpal tunnel surgery. On the right, he found "severe compression of a very edematous and erythematous right median nerve within the carpal tunnel," and on the left, "tight compression of edematous and erythematous median nerve." (Exs. 25 and 26).

Dr. Brett had earlier explained that, although claimant's nerve conduction tests were normal, her symptoms of dyesthesia were clearly in the median nerve distribution involving the middle and index fingers. (Ex. 21). Dr. Rabie had also noted nocturnal paresthesia involving the second, third and fourth fingers, especially of the right hand, as early as August 26, 1991. (Ex. 9-2). Dr. Brett also found positive Phalen's and Tinel's signs. (Ex. 17). In addition, he recognized claimant's functional overlay, but opined that, nevertheless, claimant had clinical carpal tunnel syndrome as a result of her work activities. Furthermore, although Dr. Setera, who treated claimant's low back on one occasion, reported wrist swelling in November 1990, there is no medical evidence that claimant had a wrist condition that preexisted her work with the employer, and there is no evidence that any off-the-job activities caused her condition.

Given Dr. Brett's findings of abnormal median nerves during his surgical procedures, we are less persuaded by the opinions of the other medical examiners. Weiland v. SAIF, 64 Or App 810, 814 (1983); Somers v. SAIF, 77 Or App 259 (1986). Dr. Fuller opined that, at most, claimant had a "slight reactive tenosynovitis of the flexor tendons of her fingers and wrists," which improves rapidly with anti-inflammatory medication. Claimant had been treated with anti-inflammatories and her condition did not improve. Dr. Fuller also opined that claimant could not have sustained nerve damage as a result of a "few days' work." Claimant had been performing work that included daily buffing and polishing brass by hand for a part of each shift from April 5, 1991 until after she sought treatment for her hand pain on August 3, 1991, a period of four months.

We consequently conclude that claimant's bilateral wrist condition has been established by objective findings and that her work activities are the major contributing cause of her 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 $4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 23, 1993 is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $4,000 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
MICHAEL VAN PATTEN, Claimant
WCB Case No. C4-00516
INTERIM ORDER REFERRING FOR HEARING
Coons, Cole & Cary, Claimant Attorneys
Judy Johnson, Defense Attorney

Reviewed by Board Member Hall and Haynes.

On February 28, 1994, 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 March 25, 1994, the Board received the insurer's "Motion to Disapprove Claim Disposition Agreement" and accompanying affidavit. The insurer requested disapproval of the CDA, based on ORS 656.236(1)(b), which provides that a CDA shall become final unless the Board finds the proposed disposition is the result of an intentional misrepresentation of material fact. Specifically, the insurer contends that claimant has misled the insurer into believing that he had no prior back injuries, and that, as a result of his compensable May 3, 1993 injury with the employer, claimant was unable to return to regular work.

The insurer has submitted its affidavit averring that claimant's landlord has informed the insurer that claimant had previously sustained a back injury in another state, and that claimant has demonstrated the capacity to perform heavy work. Additionally, the insurer has subsequently issued a "back-up" denial of claimant's back claim, pursuant to ORS 656.262(6), and claimant has now requested a hearing from that denial. (WCB No. 94-04822).

Alternatively, the insurer contends that if the CDA is not disapproved based on the evidence submitted, this matter should be deferred, pending a decision by a referee on claimant's request for hearing from the "back-up" denial.

Claimant has responded to the insurer's motion, asserting that the accusations made by his landlord are false. Claimant argues that the insurer has not shown evidence of a material misrepresentation on claimant's part. Finally, claimant requests that the Board deny the insurer's motion to disapprove the CDA on the basis of a material misrepresentation.

Claimant also argues that, because ORS 656.236(1) provides that submission of a CDA "shall stay all other proceedings" and payment obligations, except for medical services, on that claim, the insurer cannot issue a denial while the CDA is pending. Claimant further argues that we should not delay this matter to await the outcome of a hearing on the "back-up" denial, as the hearing is also a proceeding that must be stayed while the CDA is pending.

We do not agree with claimant that the insurer is precluded from issuing a denial on this claim. We do not construe the term "proceedings" in ORS 656.236(1) to include actions taken by an insurer. Rather, we conclude that the term "proceedings" refers to action taken at the Board and/or Hearings level. See OAR 438-09-030(1)(Notwithstanding OAR 438-06-081, 438-06-091, 438-11-020 and 438-11-025, the Board's receipt of a claim disposition agreement shall suspend all other proceedings before the Board and the Hearings Division until completion of action upon that agreement, except that the Board shall accept and file requests for hearing and Board review for purposes of establishing jurisdiction.).

However, we do agree with claimant that a hearing on the insurer's "back-up" denial of the claim is a proceeding which must be stayed pending a decision on the submitted CDA. ORS 656.236(1); OAR 438-09-030(1). Consequently, because the parties' CDA has been acknowledged and is currently before us, we decline the insurer's request to defer this matter until a hearing can be held on the "back-up" denial. As provided in the Board's rule, any hearing on that claim must await the approval or disapproval of the parties' CDA.

Nevertheless, in light of the parties' contrary positions, we conclude that it is appropriate to refer this matter to the Hearings Division for the sole purpose of a fact finding hearing on the issue raised by the insurer's motion; i.e., whether the proposed CDA is the result of an intentional misrepresentation of material fact.[1]

Accordingly, we refer this matter to the Hearings Division and to the Presiding Referee to assign this matter to a referee. We retain jurisdiction over this matter. Following the hearing, the assigned Referee is instructed to issue a recommendation concerning what action we should take regarding this claim disposition matter. Once the Referee's recommendation is issued, the parties shall advise us of their respective positions regarding that recommendation. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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[1] In Michael L. Clark, 43 Van Natta 61 (1991), the Board disapproved a proposed CDA on the ground that the CDA was the result of an intentional misrepresentation of material fact. ORS 656.236(1)(b). In Clark, the employer entered into a CDA with the claimant, based on its belief that the claimant was permanently and totally disabled because he could perform only sedentary work and could not obtain employment. Following submission of the CDA to the Board, the employer apparently obtained the claimant's employment records. The records indicated that, prior to entering into the CDA, the claimant had declared, for purposes of employment, that he was able to perform heavy work and that he was employed as a landscaper and an electrician. Because the claimant in Clark did not adequately explain the discrepancies between the records and his representations during CDA negotiations, the Board set aside the CDA on the basis that the agreement was the result of an intentional misrepresentation of material fact.

We conclude that the present case is distinguishable from Clark, and therefore, we find that a fact finding hearing is necessary. In Clark, the claimant did not provide an adequate explanation for the aforementioned discrepancies. In the present case, however, claimant has provided his explanations for his representations regarding a prior injury and his work capacity. Accordingly, because claimant's statements and the statements of his landlord cannot be reconciled, we find that this case involves an issue of credibility, and a fact finding hearing is required in order to gauge the credibility and/or reliability of the parties involved.

In the Matter of the Compensation of
SANDRA L. BRECHTEL, Claimant
WCB Case No. 92-11729
SECOND ORDER OF DISMISSAL
Doblie & Associates, Claimant Attorneys
VavRosky, et al., Defense Attorneys

On May 17, 1994, we withdrew our April 19, 1994 order which dismissed the self-insured employer's request for review of Referee Barber's order that set aside its denial of claimant's aggravation claim for a right elbow condition. Our dismissal order had issued in conjunction with our approval of the parties' "Disputed Claim Settlement," which resolved this dispute, as well as those issues which were pending before the Hearings Division in WCB Case No. 93-12524. Our abatement order was prompted by our receipt of the parties' proposed "Stipulation and and Agreement" which clarified their intentions regarding the settlement which we had previously approved. Specifically, pursuant to the stipulation, the parties acknowledge that a March 3, 1992 Notice of Closure is the last arrangement of compensation.

Inasmuch as a Claim Disposition Agreement (CDA) was pending before us when we received the aforementioned stipulation, we were unable to proceed with our review of the stipulation. See OAR 438-09-030(1). Consequently, in order to retain jurisdiction to consider and approve the stipulation, we issued our abatement order.

On May 26, 1994, the parties' CDA received Board approval. Since the stay no longer exists, we proceed with our consideration of the proposed stipulation. We have approved the parties' stipulation, thereby fully and finally resolving this dispute.

Accordingly, as supplemented herein, we republish our April 19, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES D. EVENS, Claimant
WCB Case No. 93-07218
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Mills' order that dismissed his request for hearing on the ground that claimant had abandoned his hearing request. On review, the issue is propriety of the Referee's dismissal order.

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

On review, claimant contends that the Referee should have permitted claimant's counsel to proceed in claimant's absence. Williams v. SAIF, 99 Or App 367 (1989). Claimant also argues that the record is inadequately developed, and that the Referee's order is based on an "off the record discussion." We disagree.

Following the parties' "off the record" discussion, the Referee went on the record and stated that there had been no recent, personal contact between claimant and his attorney, and claimant's counsel did not know why claimant was not present. The Referee informed the parties that, if claimant had a reason for not appearing, he could move to reconsider. The Referee stated, on the record, that his dismissal was based both on a "failure to prosecute as well as a failure to appear...".

Claimant's counsel made no objection to the Referee's ruling and did not move to proceed without claimant. Furthermore, counsel did not disagree with the Referee's characterization of the "off record" discussion. Finally, claimant did not move for reconsideration, following issuance of the Referee's order.

Accordingly, because there was no request to proceed to hearing in claimant's absence, and in light of claimant's failure to request a postponement or reconsideration of the Referee's order, we conclude that the Referee properly dismissed claimant's request for hearing, on the ground that claimant abandoned his request for hearing. See OAR 438-06-071.

ORDER

The Referee's order dated September 28, 1993 is affirmed.

In the Matter of the Compensation of
CHARLES J. HAWKES, Claimant
WCB Case No. 92-13425
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

The insurer requests review of Referee Menashe's order that: (1) found that claimant was not precluded from litigating compensability of his low back condition; and (2) set aside its denial of claimant's claim for his low back condition. On review, the issues are res judicata and compensability. We reverse.

FINDINGS OF FACT

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

Claimant was injured on December 5, 1989, when shelves fell on him at work. The shelves struck claimant on the head, neck and shoulder on the left side. Claimant was initially diagnosed with a face contusion.

On January 3, 1990, claimant began treating with Dr. Mulnick, chiropractor. Claimant's complaints included headaches, left shoulder pain and mid and low back pain.

On March 20, 1990, claimant was examined by Dr. Bussanich, chiropractor. Dr. Bussanich diagnosed cervical and thoracic strain, myofacitis, mild lumbar strain and lumbar and left sacroiliac sprain. Dr. Bussanich recommended an exercise rehabilitation program, which claimant attended through May 21, 1990.

On July 2, 1990, claimant was examined by Dr. Duncan, chiropractor, who diagnosed left-sided head, neck and shoulder contusions, related to the December 1989 injury. On July 9, the insurer accepted claimant's disabling "left-sided head, neck and shoulder contusions."

On July 10, 1990, the insurer issued a partial denial of the rehabilitation program authorized by Dr. Bussanich. Claimant appealed the denial.

An August 9, 1990 Determination Order (DO) closed claimant's claim with no award of permanent disability. Claimant appealed the DO, seeking awards of scheduled and unscheduled permanent disability and modification of the medically stationary date. The insurer sought authorization to offset overpaid temporary disability benefits against future permanent disability awards.

On September 20, 1990, claimant was seen by Dr. Gerry on referral for treatment of back and neck pain.

On November 26, 1990, Dr. Mulnick reported that, due to claimant's chronic instability of the left hip and lower back (present the last time he examined claimant), heavy lifting or physical work would have been difficult to impossible for claimant to perform.

On January 7, 1991, the insurer rescinded its previously issued denial of the rehabilitation program recommended by Dr. Bussanich.

On February 21, 1991, the parties' stipulated order awarding claimant 10 percent unscheduled permanent disability was approved by a referee. The stipulation provided that claimant withdrew all issues except for the unscheduled permanent disability award. The stipulation further provided that:

> "In consideration of the above promised payments, claimant stipulates and agrees that the Request for Hearing shall be dismissed with prejudice and said amount shall be accepted in compromise and settlement of all issues and claims raised and all issues and claims raiseable as of the date of the referee's signature hereon."

Claimant continued to receive treatment in 1991 and 1992 for his low back pain.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the February 1991 stipulated order did not preclude claimant from litigating compensability of his low back condition. The Referee reasoned that, because the insurer had paid for all treatment through the date of the stipulation, claimant would have no reason to believe that the low back condition would be denied in the future. We reverse.

Subsequent to the Referee's order, the court issued its decision in Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). In that case, the claimant had an accepted right wrist strain, and was subsequently diagnosed with a radial nerve entrapment condition. The claimant's treating doctor requested surgery authorization for the nerve condition. On that same day, the parties entered into a stipulated settlement. The settlement provided that the accepted right wrist claim would remain in closed status with all issues which were raised or which could have been raised on or before the date of approval of the settlement, having been resolved with prejudice. Id.

In Stoddard, the referee found, and we agreed, that the claimant was not precluded from litigating the nerve condition. We reasoned that the claimant did not intend to waive her right to claim compensability of the radial nerve condition, and because the insurer had not denied the condition, the compensability issue was not ripe and therefore, could not have been waived. Joyce E. Stoddard, 44 Van Natta 2530 (1992). The Stoddard court reversed, holding that the correct inquiry was whether the claimant's condition and its compensability could have been negotiated before approval of the settlement. See also Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993).

The Stoddard court found that the settlement expressly stated that it was resolving all issues which were raised or which could have been raised on or before the date the settlement was approved. Additionally, the court held that the claimant's condition was related to the compensable injury, and the treating doctor had diagnosed the condition and had requested medical services at the time the settlement was signed by the parties. Because the compensability of the condition was an issue that could have been raised prior to the settlement being approved, the court held that the claimant's nerve condition claim was barred by the stipulated settlement. Good Samaritan Hospital v. Stoddard, supra.

We find the present case to be similar to Stoddard. Here, prior to the stipulated settlement, claimant's treating doctor and several other doctors had diagnosed a low back condition. Claimant received treatment for the condition and his condition had been tied to the compensable injury, before the parties entered into the stipulation. Moreover, Dr. Mulnick, claimant's treating doctor, had opined that claimant's low back and hip condition would make it difficult to impossible to perform heavy lifting or physical work. As the dissent points out, the entire circumstances raised questions regarding the legal status of claimant's low back condition at the time of the stipulation. Such questions were ripe for negotiation and, if necessary, litigation.

Under the circumstances, we conclude that the facts of this case establish that compensability of claimant's low back condition could have been negotiated before approval of the settlement. Although the insurer may have paid for some of claimant's treatment and there was no written denial of the low back condition prior to the approval of the stipulation, the court in Stoddard disagreed with the Board's understanding that the condition in question must first be formally denied before a worker could be held to have settled a claim for that condition.[1]

Finally, as in Stoddard, the stipulation in this case expressly states that the amount received, "shall be accepted in compromise and settlement of all issues and claims raised and all issues and claims raisable as of the date of the referee's signature hereon." In the present case, we conclude that claimant's low back condition was an issue that could have been raised before February 21, 1991. Therefore, claimant's claim is barred by the stipulated settlement. Consequently, we reverse the Referee's order.

ORDER

The Referee's order dated April 26, 1993 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $2,000 is also reversed.

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[1] It appears that a claim for the low back condition was made and it was de facto denied prior to the stipulation.

Board Member Gunn dissenting.

Inasmuch as I do not find that the prior stipulation precludes claimant from establishing the compensability of his low back condition, I respectfully dissent from the majority's conclusion.

In reaching its conclusion that claimant is precluded from asserting the compensability of his low back condition, the majority relies on the provisions of a February 1991 stipulation. As noted in the majority opinion, the stipulation resolved disputes regarding an August 1990 Determination Order and claimant's entitlement to an attorney fee for the insurer's rescission of a denial of claimant's rehabilitation program. In particular, the majority cited a provision which stated that the stipulation settled "all issues raised and all issues and claims raiseable as of the date of the referee's signature hereon."

Reasoning that the scope of the insurer's acceptance of claimant's December 1989 injury claim (the insurer had accepted claimant's head, neck, and shoulder conditions) was an issue or claim which was raisable at the time of the stipulation, the majority concludes that claimant is now precluded from arguing that his low back condition is directly related to the December 1989 industrial accident. In reaching its conclusion, the majority applies the court's holding in Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). I find Stoddard distinguishable for the following reasons.

In Stoddard, the court reversed a Board order which had found that a prior stipulation concerning the closure of an accepted wrist claim did not preclude the claimant from subsequently asserting the compensability of a radial nerve condition/surgery. The stipulation had provided that the wrist claim would remain in closed status "with all issues which were raised or which could have been raised" by the date of the stipulation's approval "having been resolved with prejudice." Although the claimant's physician had diagnosed the nerve condition and recommended treatment at the time of the stipulation, the Board had reasoned that the claimant had not intended to waive her right to claim compensability of that condition. Concluding that the nerve condition was causally related to the accepted wrist injury, the Board had held that the nerve condition was compensable.

Noting that neither party was contending that the agreement was ambiguous, the Stoddard court examined whether the Board had made a legal error in construing the agreement. Citing Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993), the Stoddard court identified the correct inquiry as whether the claimant's condition and its compensability could have been negotiated before approval of the stipulation.[1] Inasmuch as the nerve condition had been diagnosed and the medical services requested at the time of approval of the stipulation, the Stoddard court determined that the nerve condition was an issue that could have been raised before the approved stipulation. Consequently, the Stoddard court held that the nerve claim was barred by the stipulation.

Here, as in Stoddard, prior to the stipulation, claimant's treating doctor and several other doctors had diagnosed a low back condition. Moreover, claimant had received treatment for his low back condition, which had been related to the industrial accident. Finally, Dr. Mulnick, claimant's treating physician, had concluded that claimant's low back and hip condition would make it difficult to impossible for claimant to perform heavy lifting or physical work.

Consequently, in the absence of any ambiguities, the parties' stipulation (containing the settlement of "all issues and claims raisable" provision) would likely preclude claimant from now asserting that his low back condition was directly attributable to the industrial accident. However, after examining the terms of the stipulation in light of the circumstances surrounding that agreement, I must conclude that the stipulation was ambiguous.

To begin, the stipulation recited that the insurer had previously accepted claimant's claim for "left-sided head, neck and shoulder contusion." Nevertheless, the agreement further acknowledged that the insurer had rescinded its appealed denial of a physical rehabilitation program recommended by Dr. Bussanich. That recommendation was designed to address cervical, thoracic, and lumbosacral complaints.

Such events raise questions regarding the status of claimant's low back condition as of the date of the stipulation. These uncertainties become even greater after reviewing the apparent basis for the stipulation's permanent disability award. The stipulation provided that claimant would receive a 10 percent unscheduled permanent disability award. Yet, at the time of the stipulation, as represented by the opinions offered by Dr. Mulnick, claimant's permanent impairment was solely attributed to limitations in his left hip and low back. (Exs. 7A, 14A). In fact, Dr. Mulnick had concluded that claimant's head, neck, upper back, and left shoulder injuries had all fully recovered. (Ex. 7A).

Thus, when viewed in context of the surrounding events, the stipulation acknowledged the insurer's withdrawal of a denial of a rehabilitation program which was designed to treat (among other conditions) a lumbosacral condition. In addition, the stipulation granted an unscheduled permanent disability award when the only basis for such an award was low back and left hip limitations.

In light of such circumstances, I submit that the stipulation was ambiguous regarding its effect on claimant's low back condition. If anything, a reasonable construction of the stipulation suggests that claimant's lumbosacral condition is being processed as part of his December 1989 injury claim. When viewed in such a manner, it would be inappropriate to interpret the "all issues and claims raiseable" settlement provision as pertaining to claimant's low back condition. Since, at a minimum, the stipulation is subject to more than one interpretation regarding its effect on claimant's low back condition, I would not construe the stipulation's provision settling "all issues and claims raiseable" as a bar to claimant's current contention concerning the compensability of his low back condition.

Turning to the merits, I would agree with the Referee's conclusion that claimant has established that his December 1989 industrial accident was a material contributing cause of his need for medical treatment or disability for his low back condition. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Accordingly, based on the foregoing reasoning, I respectfully dissent from the majority's decision to uphold the insurer's denial.

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[1] I likewise distinguish this case from Seney. There, the court held that a prior stipulation concerning the claimant's appeal of a Determination Order regarding an accepted shoulder claim precluded the claimant from subsequently bringing a "new injury" claim for the same shoulder condition. Reasoning that regardless of whether the claimant's condition was characterized as an aggravation or as a new injury, the Seney court concluded that the claimant's shoulder condition and the compensability of a potential claim were at issue during the negotiations and before the approval of the stipulation (which contained a provision that all issues which were raised or could have been raised on or before the date of referee approval were resolved).

Here, unlike Seney, I am unable to conclude that claimant's presently disputed low back condition was a raisable issue when the stipulation was approved. At the time of the stipulation, there is no indication that any medical service or any other benefit arising from claimant's low back condition had been either rejected or left unpaid. In fact, if anything, the stipulation suggests that claimant's low back condition was part of claimant's accepted claim and formed the basis of claimant's stipulated permanent disability award.

In the Matter of the Compensation of
JORGE E. MENDEZ, Claimant
WCB Case No. 93-05567
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Nichols' order which reduced his scheduled permanent disability award for loss of use or function of the left wrist from 8 percent (12 degrees), as awarded by an Order on Reconsideration, to 3 percent (4.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's left wrist was lacerated at work by a piece of lumber. A Notice of Closure issued on January 13, 1993, awarding claimant no scheduled permanent disability. On reconsideration, claimant was awarded 3 percent (4.5 degrees) permanent disability for loss of range of motion, and 5 percent (7.5 degrees) for a chronic condition limiting repetitive use, for a total of 8 percent (12 degrees) scheduled permanent disability.

The Referee modified the Order on Reconsideration, concluding that the medical evidence was not sufficient to support a permanent disability award for a chronic condition. We disagree.

OAR 436-35-010(6) provides:

> "A worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent condition as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow, and arm."

The rule requires medical evidence of at least a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 1452 (1993).

Claimant's treating physician did not report the existence of a chronic condition that would limit repetitive use of claimant's left wrist. However, the medical arbiter stated:

> "Currently, he complains of sharp pain along the radial left wrist, especially with deviating the wrist toward the ulnar side. He notes numbness at the base of the thumb, and pain in the radial side of the wrist with heavy lifting. He feels less strong in the left wrist with forceful grasp, push, pull, or lift, than the right. He notes his left wrist pain is aggravated by heavy lifting * * *."
>
> * * * * *
>
> "5. Based on today's subjective history and objective examination, it is my medical opinion, based on reasonable medical probability, that the patient will have some difficulty with repetitive forceful use of the left wrist, particularly radial deviation and dorsiflexion type activities. He could perform some repetitive use of the wrist in a lighter manner." (emphasis supplied)

We understand the doctor to state, and we conclude, that claimant has suffered a partial loss of ability to repetitively use the left wrist. Accordingly, claimant is entitled to a chronic condition award. Therefore, based on the arbiter's opinion, we conclude that claimant is unable to repetitively use his left wrist due to a chronic and permanent condition. OAR 436-35-320(5). Donald E. Lowry, supra. Consequently, we reinstate and affirm the reconsideration order award of 8 percent scheduled permanent disability. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order (the 5 percent increase from the Referee's award to this award), not to exceed $3,800, payable directly to claimant's attorney. ORS 656.386(2); OAR 438-15-055(1).

Claimant is also entitled to an assessed attorney fee for successfully defending against the SAIF Corporation's request for hearing because the compensation awarded to claimant by the Order on Reconsideration has not been disallowed or reduced. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing 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 the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 16, 1993 is reversed. The April 19, 1993 Order on Reconsideration, which awarded claimant 8 percent (12 degrees) scheduled permanent disability, is reinstated and affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order (the 5 percent increase from the Referee's order), not to exceed $3,800, payable directly to claimant's attorney. For services at hearing, claimant's attorney is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

Board Member Haynes dissenting:

The plain language of the arbiter's report states that claimant will have "some difficulty with repetitive forceful use * * * ." (Emphasis added). That does not establish that claimant is prevented from repetitively using his wrist. See Eilene E. Harding, 45 Van Natta 1484 (1993). Furthermore, it is not evidence of a partial loss of ability to repetitively use the wrist. Donald E. Lowry, supra. Finally, the arbiter also stated that claimant could perform repetitive use in a lighter manner.

I do not consider the arbiter's statement sufficient to establish a chronic and permanent condition. Accordingly, I dissent.

In the Matter of the Compensation of
JULIE A. WIDBY, Claimant
WCB Case No. 93-08139
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of Referee T. Lavere Johnson's order that found that claimant was not entitled to an award of unscheduled permanent disability, whereas an Order on Reconsideration awarded 11 percent (35.2 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant contends that, because claimant's injury was accepted by the self-insured employer, any findings made by the medical arbiter support an award of permanent disability, as it is the arbiter's job to rate only impairment arising from the accepted injury. We disagree.

Although the arbiter rates impairment pursuant to ORS 656.268(7), there is no requirement that the arbiter report only impairment findings that are due to the compensable injury. Furthermore, in the present case, the arbiter's report was not limited to merely a listing of claimant's impairment findings. Following the impairment findings, Dr. Ayers, the arbiter, also provided comments pertaining to other causes of claimant's impairment, such as her weight, smoking, and lack of fitness.

Finally, ORS 656.214(5) provides that the "criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis supplied). Here, for the reasons stated in the Referee's order, we agree that claimant has not established by a preponderance of the medical evidence that she is entitled to an award of permanent disability. ORS 656.726(3)(f)(B).

ORDER

The Referee's order dated October 7, 1993 is affirmed.

Board Member Hall dissenting.

I do not necessarily agree with claimant's premise that any findings made by a medical arbiter must be used to support an award of permanent disability. However, in the present case, I would find that the arbiter's report does support such an award.

Here, the Department provided Dr. Ayers with its July 1, 1992 version of "Instructions to Medical Arbiters." One of the instructions provided that the arbiter was to perform an examination of the low back and upper extremities and report any objective permanent impairment resulting from the accepted condition only...". (Emphasis in the original).

Accordingly, because Dr. Ayers reported range of motion findings, there is no reason to believe that he was not following the Department's instructions and reporting only permanent impairment resulting from the accepted condition. There is no basis to reject the range of motion findings reported by Dr. Ayers. Dr. Ayers did state that claimant's functional residual capacity would be within the category of medium, "and is basically related to her pre-existing sacralization of L5 compounded by her work exposure, obesity and cigarette abuse". I would not find that these comments regarding adaptability should defeat claimant's entitlement to an impairment award for loss of range of motion. Although such a comment might defeat a value for adaptability, it should not be grounds for rejecting valid range of motion findings resulting "from the accepted conditions only."

For the aforementioned reasons, I respectfully dissent from the majority opinion.

June 1, 1994 Cite as 46 Van Natta 1066 (1994)

In the Matter of the Compensation of
ROSE L. DIXON, Claimant
WCB Case No. 93-03057
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

On May 6, 1994, we withdrew our April 13, 1994 order that: (1) affirmed that portion of the Referee's order which awarded 5 percent scheduled permanent disability for the right wrist; and (2) reversed that portion of the Referee's order which declined to authorize an offset. We took this action to retain jurisdiction to consider the parties' proposed settlement of this dispute.

The parties have submitted a proposed "Stipulation and Order/ Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders. Specifically, claimant agrees that the self-insured employer's partial denial of claimant's current right wrist condition, as set forth in the settlement, "shall remain in full force and effect." In addition, claimant stipulates that the Referee's 5 percent scheduled permanent disability award should be reversed. The employer also agrees to waive its entitlement to recover any overpaid temporary disability benefits. Finally, the agreement provides that this matter "shall be dismissed with prejudice."

We have approved the settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. In other words, the Referee's 5 percent scheduled permanent disability order is reversed and our prior offset authorization is vacated.

Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROGER D. JOBE, Claimant
WCB Case Nos. 92-15112 & 92-10152
ORDER ON RECONSIDERATION
Gary D. Taylor, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

The SAIF Corporation, on behalf of R. Keith Foster, a noncomplying employer, requests that we amend our May 6, 1994 order to indicate that we upheld its denial of claimant's C5-6 herniated disc. We treat SAIF's request as a request for reconsideration of that portion of our May 6, 1994 Order on Review that affirmed the Referee's order.

In our initial order, we affirmed the Referee's opinion with supplementation. In the last paragraph of our discussion, we noted that SAIF had denied claimant's diagnosed C5-6 disc herniation and headaches. We found that claimant's disc condition was not a compensable consequence of his 1981 injury, but that his headaches were a component of the compensable chronic pain syndrome that resulted from the 1981 injury. We affirmed the Referee's order, which had found claimant's "current condition including his headaches and neck complaints are compensable conditions resulting from the 1981 accepted claim."

We accordingly modify the Referee's order to uphold that portion of SAIF's denial that denied claimant's C5-6 disc herniation. The denial is set aside as to the remaining conditions.

Our May 6, 1994 Order on Review is withdrawn. On reconsideration, as modified herein, we adhere to and republish our May 6, 1994 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIM AND TERRY JONES, dba ACE TREE COMPANY, Noncomplying Employer
WCB Case No. 93-07172
SECOND ORDER OF DISMISSAL
Michael B. Dye, P.C., Claimant Attorneys
Roberts, et al., Defense Attorneys

Timothy and Terry Jones, dba Ace Tree Company (Ace Tree), an alleged noncomplying employer, request reconsideration of our May 6, 1994 order that dismissed its request for Board review for lack of jurisdiction. Ace Tree contends that, because the Referee awarded claimant's counsel an assessed attorney fee, the hearing before Referee Lipton encompassed a matter concerning a claim, and therefore, the Board has review authority over the Referee' order. On reconsideration, we continue to hold that appellate jurisdiction lies with the Court of Appeals under ORS 656.740(4).

In his order the Referee stated:

> "Claimant's right to receive compensation was at risk in this proceeding. Were I to uphold the employer's position that the June 2, 1993 Proposed and Final Order was of no legal effect, claimant's right to receive compensation would be put at risk because SAIF might then choose to issue a back-up denial. Consequently, although I affirm the Proposed and Final Order, claimant's counsel is entitled to an attorney's [sic] fee payable by Ace Tree Company."

Based on the Referee's statements, Ace Tree contends that claimant's right to receive compensation was directly in issue. Thus, Ace Tree reasons that the Director's June 2, 1993 noncomplying employer order was contested at the same hearing as a matter concerning a claim, and, therefore, we have review authority over the Referee's order.

In Jose Castillo, 45 Van Natta 846 (1993), we affirmed Referee Johnson's order finding claimant's claim compensable and Timothy and Terry Jones, dba Ace Tree Company, to be the responsible employer. However, we modified that portion of the Referee's order which remanded the claim to SAIF for processing. Rather, because a NCE order as to the Joneses had not yet issued by the Department, responsibility for directing the processing of Castillo's claim remained with the Department. Id.

When the Department issued a NCE order as to the Joneses, this proceeding was initiated. The status of the Castillo claim was not at issue, although we had stated in Jose Castillo, supra, that since the subjectivity issue had been fully litigated with all parties present, our holding would likely have a preclusive effect on SAIF's future processing of the claim.[1]

Here, the Joneses' challenge to the NCE order was solely confined to the legal effect of that order. No issues regarding the compensability of Castillo's claim were raised. Therefore, the Referee may have been incorrect in awarding an attorney fee, but jurisdiction to correct any error is with the Court of Appeals, not the Board. See Kyoto Restaurant, 46 Van Natta 1009 (1994) (Board dismissed, for lack of jurisdiction, the claimant's request for Board review of a stipulation between the Department and the noncomplying employer which affirmed the NCE order. Board held that the claimant's request for an assessed attorney fee rested with the Court of Appeals.).

Moreover, carrier-paid attorney fees are not compensation. See Steiner v. E. J. Bartells Co., 114 Or App 22 (1992); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986). Consequently, such an award would not constitute a matter concerning a claim because claimant's right to receive compensation, or the amount thereof, would not be directly in issue. See ORS 656.704(3).

In conclusion, we continue to find that no issues regarding a matter concerning a claim were contested at the hearing. We adhere to our holding that appellate review authority over the Referee's order rests with the Court of Appeals.

Accordingly, we withdraw our May 6, 1994 order. On reconsideration, as supplemented herein, we republish our May 6, 1994 Order of Dismissal. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Either claimant or the Joneses could subsequently challenge SAIF's ultimate decision of the claim.

June 1, 1994 Cite as 46 Van Natta 1068 (1994)

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case Nos. 92-16492 & 93-01866
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer requests abatement and reconsideration of our May 6, 1994 Order on Review that reversed those portions of the Referee's order finding that claimant's right shoulder and neck condition claim and left foot injury claim were prematurely closed. Additionally, our order determined claimant's entitlement to permanent disability for each claim. In seeking reconsideration, the employer requests an offset of any temporary disability benefits it paid pursuant to the Referee's order pending review against the additional permanent disability awarded on review.

In order to consider the employer's motion, we withdraw our May 6, 1994 order. The parties are granted an opportunity to submit supplemental arguments regarding the employer's request. In submitting their respective arguments, the parties are requested to discuss the effect, if any, the Board's holding in Debbie L. Stadtfeld, 44 Van Natta 1474 (1992) has on this issue. Each submission must be filed within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLINTON C. BUZZARD, Claimant
WCB Case No. 93-02257
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

The self-insured employer requests reconsideration of our May 12, 1994 Order on Review which: (1) set aside its denial of claimant's current low back condition; and (2) awarded a carrier-paid attorney fee of $5,000. Contending that the attorney fee award is excessive, the employer seeks reconsideration and reduction of the award.

In order to further consider the employer's motion, we withdraw our May 12, 1994 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUELLA E. CLARK, Claimant
WCB Case No. 93-08182
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Hall.

The self-insured employer requests review of Referee Emerson's order that awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of her right arm (elbow), whereas an Order on Reconsideration awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 5 percent permanent disability due to a chronic condition based on claimant's testimony and the report of Dr. Wigle, claimant's treating physician. We disagree.

Claimant may be entitled to a permanent disability award due to a chronic condition "when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition...". Former OAR 436-35-010(6)(WCD Admin. Order 2-1992). Any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings. Jill C. Van Horn, 44 Van Natta 1523, 1524 (1992); William K. Nesvold, 43 Van Natta 2767 (1991); former OAR 436-35-010(1).

We conclude that the present case is similar to that of Melba P. Dougherty, 45 Van Natta 1018 (1993). In Dougherty, a panel of medical arbiters found that the claimant had a waxing and waning of ankle pain which was a chronic condition arising out of her work injury. However, the arbiter panel further found that the claimant was able to use her ankle repeatedly with intermittent pain. Consequently, the Board found that the preponderance of medical opinion, as well as the claimant's testimony, established that the claimant was able to repetitively use her foot and ankle, albeit accompanied by intermittent pain, numbness and tingling. Dougherty, id at 1018.

Here, Dr. Wigle, claimant's treating doctor, reported that claimant occasionally felt symptoms in her elbow if she did tasks without wearing her tennis elbow strap. However, claimant did not have persistent aching. Dr. Wigle found that claimant had a "minimal partial disability," however, he did not comment on any chronic condition limiting claimant's repetitive use of her right elbow.

Claimant reported to the medical arbiter, Dr. Fry, M.D., that she was working full time with no restrictions. Claimant had no soreness over her elbow, although she had occasional numbness in some fingers. Claimant felt that she had no weakness in her right arm and she was not dropping objects. If claimant failed to wear her brace, soreness returned after two weeks. Following his examination, Dr. Fry reported that claimant had no signs of an active epicondylitis and she could "repetitively use the injured arm with no restrictions."

At the hearing, claimant stated that she could use her arm and elbow repetitively, however, sometimes overuse brought on symptoms of pain.

We conclude that the preponderance of medical opinion, as well as claimant's testimony, establish that claimant is able to repetitively use her right elbow, although such use may be accompanied by occasional pain or numbness. Dougherty, supra. Accordingly, we conclude that claimant has not suffered permanent impairment due to an inability to repetitively use her right elbow. Consequently, she is not entitled to a scheduled permanent disability award.

ORDER

The Referee's order dated October 22, 1993 is reversed. The Order on Reconsideration dated June 17, 1993 is affirmed.

Board Member Hall dissenting.

I would affirm the Referee's order in this case, as I respectfully disagree with the majority's conclusion that claimant has failed to establish entitlement to a chronic condition award.

Prior to claimant's becoming medically stationary, Dr. Wigle, claimant's treating doctor, recommended a tennis elbow strap for claimant, and restricted her from lifting in a pronated fashion or performing repetitive gripping or grasping. (Ex. 15 A-2). Even after Dr. Wigle found claimant medically stationary, he believed that, "in the long run she will need to wear this tennis strap indefinitely" while at work and he recommended that she wear the brace "on a prophylactic basis if nothing else." At that time, Dr. Wigle found claimant to have a "minimal permanent partial disability in the right arm secondary to her lateral epicondylitis." (Ex. 26-2).

Under the circumstances, I would find that Dr. Wigle's opinion, his prescription of a permanent brace, and claimant's testimony regarding her need to pace herself at work, constitutes a preponderance of evidence establishing that claimant is unable to repetitively use her right elbow, due to a chronic and permanent medical condition.

In the Matter of the Compensation of
LORINDA J. GIELER, Claimant
WCB Case No. 92-08299
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Davis' order that: (1) awarded claimant temporary disability benefits from June 12, 1990 through April 9, 1992 (the date claimant was declared medically stationary), whereas an Order on Reconsideration awarded claimant temporary disability benefits from June 12, 1990 through July 10, 1990; and (2) assessed a penalty for the insurer's unreasonable resistance to the payment of compensation. On review, the issues are temporary disability benefits and penalties. We affirm.

FINDINGS OF FACT

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

Claimant's doctors completed numerous work release forms on her behalf between May 18, 1990 and July 3, 1990. Claimant gave the work release notices to the insured's workers' compensation specialist in its Human Resources Department after each doctor's visit, on the same day that she received them.

Dr. Noonan released claimant for modified work on June 12, 1990. He restricted claimant from working around chemical fumes and solvents. On that same date, Dr. Noonan spoke with the insured's Human Resources Manager and told her that claimant needed to work in a clean air environment free from fumes.

On June 19, 1990 and June 26, 1990, Dr. Noonan continued claimant's restrictions as given on June 12, 1990.

Dr. Morton, environmental medicine specialist, toured the insured's plant on July 6, 1990. In the area where claimant worked, Dr. Morton smelled cyglas resin fumes, the chemical irritant that exacerbates claimant's compensable asthmatic bronchitis. Dr. Morton gave the insured's Human Resources Manager written notice that claimant required modified work in the form of adequate ventilation or appropriate personal protection equipment.

Upon receipt of Dr. Morton's note, claimant's supervisor gave claimant a respirator. The respirator restricted claimant's breathing.

The insured's safety engineer took the respirator back from claimant. He later discovered that claimant had been issued a "negative" respirator which makes breathing more difficult.

The insured did not subsequently offer claimant modified work (either in the form of a clean air work environment or an appropriate respirator).

Claimant ceased working on July 10, 1990 because the insured did not offer her modified work compatible with her compensable respiratory condition.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

Finding that claimant was not medically stationary, had not been released for regular work, and had not been provided suitable modified work as of July 10, 1990, the Referee concluded that the insurer was obligated to continue payment of temporary disability compensation until claimant was declared medically stationary. We adopt the Referee's conclusions and reasoning with the following comments.

Under ORS 656.268(3), an insurer may unilaterally terminate temporary disability compensation in an open claim, without claimant being medically stationary, if any one of the conditions set forth in ORS 656.268(3) is met. See Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992); Rocky L. Coble, 43 Van Natta 1907, aff'd Coble v. T.W. Kraus & Sons, 116 Or App 62, 63 (1992). These conditions include: the worker's return to regular or modified employment; the worker's receipt of a written release by her attending physician to return to regular employment; and the worker's receipt of a written release by her attending physician to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. ORS 656.268(3)(a),(b),(c).

On review, the insurer argues that claimant voluntarily withdrew from the work force on July 10, 1990. Therefore, it contends, because claimant was not working for reasons unrelated to her compensable injury, claimant is not entitled to temporary disability compensation after that date. Contrary to the insurer's contentions, we find that claimant quit her job because she continued to be exposed to cyglas resin fumes that exacerbated her compensable respiratory condition. Further, we find that the employer essentially withdrew modified work by not providing either a clean air work environment or an appropriate respirator as required by claimant's physicians.

Temporary disability must be reinstated when an offer of modified employment is withdrawn. See Arturo G. Vasquez, 44 Van Natta 2433 (1992) (modified job offer withdrawn due to upcoming, regular seasonal layoffs required the insurer to reinstate temporary total disability); Shirley J. Sanderson, 44 Van Natta 484 (1992) (modified job offer withdrawn due to the employer's inability to place the worker in another modified job, when a modified job offered by the employer was determined to be beyond the worker's physical limitations, triggered the insurer's duty to begin paying temporary total disability); Kati A. Hanks, 44 Van Natta 881 (1992) (modified job offer effectively withdrawn by the employer's "lock out" entitled the claimant to temporary total disability during the "lock out"), aff'd Safeway Stores, Inc. v. Hanks, 122 Or App 582 (1993).

The same reasoning applies here. Claimant is unable to return to her regular employment due to the restrictions on exposure to cyglas resin fumes, the chemical irritant that exacerbates her compensable respiratory condition. Moreover, when the employer took back the respirator, and then neither transferred claimant to a clean air area of the plant nor provided an appropriate respirator, it effectively withdrew its modified job offer. Once the modified job offer was withdrawn, ORS 656.268(3) required the insurer to reinstate temporary disability benefits. Vasquez, supra; Sanderson, supra; Hanks, supra.

Consequently, we affirm the Referee's order awarding claimant temporary disability benefits from June 12, 1990 through April 9, 1992.

Penalty

We adopt the Referee's conclusions and reasoning on this issue.

Claimant is entitled to a reasonable assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the temporary disability issue is $800. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest to claimant. Claimant's counsel is not entitled to an attorney fee for defending the Referee's penalty assessment. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated October 18, 1993 is affirmed. For services on review concerning the temporary disability issue, claimant's counsel is awarded an attorney fee of $800, to be paid by the insurer.

In the Matter of the Compensation of
RAPHAEL IBARRA, Claimant
WCB Case No. 92-11216
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee Black's order which declined to award claimant unscheduled permanent disability. The insurer cross-requests review of that portion of the order that awarded claimant temporary disability benefits through December 12, 1991. In his brief, claimant also contends that the Referee erred in continuing an earlier Referee's evidentiary rulings that excluded Exhibits 28B and 29 from consideration on the issue of permanent impairment. On review, the issues are evidence, extent of unscheduled permanent disability and temporary disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the second "finding of ultimate fact". Claimant's compensable May 3, 1991 low back injury was closed by Notice of Closure on January 22, 1992 without an award of permanent disability. Claimant requested reconsideration. An Order on Reconsideration was issued on May 19, 1992, but it did not award any permanent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not entitled to an award of unscheduled permanent disability, finding that the medical record did not establish that claimant had measurable permanent impairment. Claimant contends that the Referee erred in not considering two "post-reconsideration" medical reports in connection with the issue of permanent impairment.

One is a September 4, 1992 medical report authored by a consulting physician, Dr. Maukonen (Ex. 28B), and the other is an October 4, 1992 medical report written by claimant's attending physician, Dr. Poulson. (Ex. 29). Dr. Poulson's report refers to his "pre-reconsideration order" examination and report of March 5, 1992 and states that claimant is unable to do repetitive activity such as bending, lifting and twisting. Dr. Poulson also relates claimant's low back condition to his original compensable injury on May 5, 1991.

Claimant concedes that Dr. Maukonen's medical report probably cannot be considered on the issue of permanent impairment because it was not authored by claimant's attending physician at the time of claim closure. See ORS 656.245(3). However, claimant asserts that Dr. Poulson's October 1991 medical report should be considered in light of Safeway Stores, Inc., v. Smith, 122 Or App 160 (1993).

We need not decide the evidentiary issue. We find instead that Dr. Poulson's March 5, 1992 medical report, which lists claimant's range of motion findings, is sufficient to rate claimant's permanent impairment. At that time, claimant had 40 degrees of flexion and 20 degrees of extension. (Ex. 21).

The Referee did not consider Dr. Poulson's March 5, 1992 medical report, issued prior to the reconsideration order, with respect to the permanent impairment issue, because it was issued after claim closure and reported on claimant's condition after claim closure. However, subsequent to the Referee's order, we held that a "post-closure" medical report based on a "post-closure" medical examination can be considered in determining the extent of a claimant's permanent disability. Cynthia L. Luciani, 45 Van Natta 1734 (1993). Accordingly, we consider Dr. Poulson's March 5, 1992 medical report on the permanent disability issue.

The issue then becomes whether or not Dr. Poulson's March 1992 report is sufficient evidence that claimant has permanent impairment attributable to his compensable low back injury. Although Dr. Poulson's March 5, 1992 report does not relate the reductions in range of motion to claimant's compensable 1991 low back injury, his October 1992 medical report does relate claimant's back condition to the original injury. (Ex. 29).

Although we do not decide the issue of whether Dr. Poulson's October 1991 medical report can be considered on the issue of permanent impairment, we can consider the report, which was admitted with regard to an issue not presently on appeal, on the issue of whether claimant's permanent

impairment is attributable to the compensable injury. See Orval R. Ogbin, 46 Van Natta 499, 501 (1994); Frank H. Knott, 46 Van Natta 364, 366 (1994). Accordingly, we find that Dr. Poulson's October 1992 medical report does establish that range of motion findings in the March 1992 examination are related to the compensable low back injury. Thus, we conclude that claimant does have permanent impairment attributable to the compensable 1991 low back injury. We now proceed to calculate claimant's unscheduled permanent disability.

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 January 22, 1992 Determination Order. OAR 438-10-010, 436-35-003(2). Thus, the applicable "standards," as amended by the temporary rules, are provided in WCD Admin. Orders 2-1991 and 7-1991.

Claimant's age of 43 years is assigned a value of 1. See OAR 436-35-290(2). He has no high school diploma and therefore is entitled to a value of 1 for formal education. See OAR 436-35-300(3). There is insufficient evidence that claimant has the skills necessary to perform any job with an SVP of greater than 2. We therefore assign a value of 4 for the skills factor. See OAR 436-35-300(4). Although the insurer contends that claimant's time-of-injury employment should be classified as a Farm Worker, Field Crop I, (DOT #404.663-010), which has an SVP of 5, we do not base the skills value on this employment because claimant did not perform this job for the required 6-month period. See OAR 436-35-300(4)(e). Therefore, claimant is assigned a value of 5 for the education factor (1 for formal education plus 4 for the skills factor). See OAR 436-35-300(3)(e). In addition, claimant is entitled to a value of 1 for training because he does not hold a current license or certificate of completion. OAR 436-35-300(5). The sum of the age, education, and training factors equals 7.

We next calculate the adaptability factor. While we do not base claimant's skills value on his time-of-injury job, we agree that claimant's job at injury was as a Farm Worker, Field Crop I, which had "medium" strength requirements. (DOT #404.663-010).[1] At the time of determination, claimant had performed work in the "medium" category as Tanbark Laborer (DOT #454.687-014). (See Tr. 32). We find that this employment evidences claimant's residual functional capacity. See OAR 436-35-270(3)(d)(C). Consequently, we assign a value of 1 for the adaptability factor. See OAR 436-35-310(3). Based on the range of motion findings in Dr. Poulson's March 5, 1992 report, claimant is entitled to a 6 percent rating for low back impairment. See OAR 436-35-360(7),(8).

Assembling the factors, we multiply the age, education, training factors total (7) and the adaptability value (1) for a product of 7. That product is then added to the impairment value of 6 for a total of 13 percent. See OAR 436-35-280. Claimant is entitled to 13 percent unscheduled permanent disability for the compensable injury.

Claimant's attorney is entitled to an attorney fee award payable from the increased compensation created by this order. See OAR 438-15-055. As a result of our decision, claimant's unscheduled permanent disability award has been increased from zero to 13 percent. Consequently, claimant's attorney is awarded 25 percent of this 13 percent unscheduled permanent disability award, not to exceed $3,800.

Finally, the insurer has requested that the Referee's award of temporary disability be modified due to an alleged typographical error. The Referee had awarded temporary disability from September 9, 1991 through the medically stationary date. His order recites that date as December 12, 1992. The insurer points out that claimant's medically stationary date was actually December 2, 1992. (Exs 18, 19, 20, 26). We agree and modify the award of temporary disability award accordingly.

ORDER

The Referee's order dated August 3, 1993 is modified. Claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability. Claimant's temporary disability award is modified to award temporary disability from September 9, 1991 through December 2, 1991. Claimant's attorney is awarded an out-of-compensation attorney fee in the amount of 25 percent of the 13 percent (41.6 degrees) unscheduled permanent disability compensation created by this order, not to exceed $3,800.

[1] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Michelle Cadigan, 46 Van Natta 307 (1994), Member Hall directs the parties to his dissenting opinion in that decision.

In the Matter of the Compensation of
CATHERINE S. CONYNGHAM, Applicant
WCB Case No. CV-94001
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Diane Brissenden, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Monte Marshall, special hearings officer, on April 8, 1994, in Salem, Oregon. Applicant, Catherine S. Conyngham was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Diane Brissenden, Assistant Attorney General. The court reporter was Marlene Cromwell. Exhibits 1 through 19 were received and admitted into evidence. The record was closed April 8, 1994. Mary Ellen Johnson, claims examiner for the Department, was present as a witness for the Department.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated January 7, 1993. By its order, the Department denied applicant's claim for compensation filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on its findings that: (1) it was not established that a "compensable crime" was committed within the meaning of ORS 147.005(4); and (2) applicant was not a "victim" within the meaning of ORS 147.005(12).

FINDINGS OF FACT

Applicant worked as a x-ray technician for a group of physicians for approximately 17 years. In mid-1987, Dr. Hanley joined the group of physicians as a partner. In August 1987, applicant received a phone call. The caller did not identify himself and hung up. Around the same time, applicant began noticing a red pick-up truck frequently passing by her residence.

In October 1990, applicant perceived that she was being harassed at work by her fellow employees. In November 1990, the physicians employing applicant discussed dissolution of the partnership. On November 25, 1990, applicant fell at home and sustained a severe injury to her left knee. Following the injury, applicant asked to receive vacation pay. The initial check was in the wrong amount and required applicant to spend considerable effort to obtain the correct amount.

On January 8, 1991 applicant was notified that her working hours would be reduced to 20 hours per week. On January 10, 1991, applicant submitted her resignation. At the end of January 1991, applicant applied to the employer for her pension. Applicant did not receive her pension payments and began to experience financial difficulties. In March 1991, she was informed that her pension was being held up pending receipt of Dr. Hanley's financial statements regarding the pending dissolution of the partnership.

Applicant did not receive any pension funds and began looking for work in May 1991 when she was medically released to work. Thereafter, she applied for work at three different hospitals. Following these applications, she received numerous phones calls from persons who would hang-up without identifying themselves. During this time, applicant also noticed the red pick-up truck again passing by her residence.

Applicant next applied for work at various retail stores. She did not receive any offers of work and perceived that her efforts to gain employment were being "blocked" by her former employer. Applicant continued to receive phone calls from unidentified persons and began to feel that her phone was "tapped." She contacted the phone company who indicated that applicant's phone was not tapped.

During this same time period, applicant was contacted by an attorney who represented one of applicant's former co-workers. The co-worker had filed a suit against Dr. Hanley alleging sexual harassment at work. The attorney informed applicant that he could not use any of her information as the harassment applicant was alleging was by phone and the origin of the phone calls could not be verified.

Throughout 1991, applicant continued to apply for x-ray technician positions, but was unsuccessful. In December 1991, applicant was hired by a retail store as seasonal help. During her work at the retail store, it was applicant's perception that she was being treated with suspicion by her fellow employees. In addition, applicant began to perceive that employees and other persons at places where she shopped or dined were acting suspicious around her.

Following this brief employment, applicant continued to apply for x-ray technician jobs throughout Oregon and in the Seattle area. She continued to receive phone calls and again had her phone line checked for a tap. Her phone line was clear, but she was informed that a "tapping" could occur from an undetectable source such as a "ham" radio.

Thereafter, applicant had her phone number changed and did not give it out to any person. However, she continued to occasionally receive phone calls in which the caller would hang-up after applicant answered the phone.

In August 1993, applicant filed a complaint with the Portland Police Bureau. Her complaint alleged that Dr. Hanley had been stalking and terrorizing her over the previous three years. The complaint also alleged that Dr. Hanley, or someone on his behalf, was listening to her phone calls and preventing applicant from obtaining employment. There were no charges filed against Dr. Hanley because of insufficient evidence of a criminal act or that Dr. Hanley had committed a criminal act.

In October 1993, applicant filed a claim for crime victim compensation. Applicant alleged that Dr. Hanley, or someone on his behalf, was harassing, terrorizing, and stalking her. In addition, applicant alleged that Dr. Hanley was preventing her from obtaining employment and monitoring her phone.

On November 30, 1993, the Department issued an order denying applicant crime victim compensation on the basis there was insufficient evidence that a "compensable crime" was committed within the meaning of ORS 147.005(4) and that applicant was not a "victim" within the meaning of ORS 147.005(12). Applicant requested reconsideration and by a January 7, 1994 order, the Department adhered to its original conclusion.

On February 8, 1994, applicant received an early morning phone call. The caller did not identify himself and applicant hung up the phone. Applicant trapped the caller's number and filed a complaint with the police. Police investigators contacted the person who had called applicant and determined that the person had misdialed. Applicant did not know the caller nor did the caller know Dr. Hanley.

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).

The Department's order denying compensation benefits to applicant was made on two basis. First, applicant failed to establish the commission of a a "compensable crime." Second, applicant failed to establish that she was a "victim" of a "compensable crime." I agree.

A "compensable crime" is defined by ORS 147.005(4) which states:

> "'Compensable crime' means an intentional knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state."

In conjunction with this provision, ORS 147.005(12)(a) defines a "victim" as a person "killed or injured in this state as a result of a compensable crime perpetrated or attempted against that person."

Here, applicant has alleged that Dr. Hanley, or persons acting on his behalf, has harassed, stalked and terrorized her. In addition, applicant alleges that Dr. Hanley, or persons acting on his behalf, has prevented her from obtaining employment and have monitored her phone. However, applicant has not established that Dr. Hanley, or persons acting on his behalf, committed an intentional or reckless act. This conclusion is supported by the Portland Police Department's decision not to file a complaint against Dr. Hanley because of insufficient evidence.

In addition, applicant concedes she did not suffer serious bodily injury as a result of Dr. Hanley's alleged actions. Thus, even assuming that applicant established that Dr. Hanley committed an intentional or reckless act that would be considered a crime, she has not established that such act

resulted in serious bodily injury. In this regard I note that there is no evidence in the record establishing that applicant sustained a psychological injury or sought treatment for psychological injury. Consequently, applicant has not established that a compensable crime was committed, nor has she established that she was a victim of a compensable crime within the meaning of ORS 147.005(4) and 147.005(12)(a). Accordingly, applicant has not established her entitlement to benefits.

In reaching this conclusion, I recognize that applicant has been subjected to emotional trauma. Yet, to recover benefits as a victim of a crime under the Act, the Legislature has mandated that several specific prerequisites must be satisfied. For the reasons detailed above, applicant has not satisfied those prerequisites. Inasmuch as applicant's claim does not satisfy all of the statutory requirements for receiving benefits under the Act, she is not entitled to benefits. Finally, I note that should applicant obtain more evidence concerning the criminal conduct alleged herein or future conduct that would constitute a "compensable crime", she may ask the Department to reconsider her application or file a new application.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated January 7, 1994 be affirmed.

May 6, 1994 Cite as 46 Van Natta 1077 (1994)

In the Matter of the Compensation
BILLIE I. ENSLEY, Claimant
WCB Case No. 93-03765
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

The insurer requests reconsideration of our March 11, 1994 Order on Review which adopted and affirmed the Referee's order finding claimant's current neck condition compensable as a consequential condition under ORS 656.005(7)(a)(A). Specifically, the insurer contends that claimant's neck condition, caused by the physical therapy regimen prescribed for her compensable low back condition, is not compensable unless claimant establishes that the compensable injury itself was the major contributing cause of the neck condition. The insurer contends that we erred in holding the claim compensable based on a finding that the physical therapy regimen was the major contributing cause of the neck condition.

On April 8, 1994, we withdrew our March 11, 1994 order for reconsideration. Claimant's response to the insurer's motion has been received. Accordingly, we proceed with our reconsideration.

In our original order we affirmed the Referee's order with supplementation. Citing George Hames, Jr., 45 Van Natta 2426 (1993), we stated that because claimant proved that her physical therapy regimen, prescribed for a compensable low back condition, was the major contributing cause of her current neck condition, she had established compensablility of her current condition. We acknowledge that this is an incorrect statement of the law. Accordingly, we withdraw the fourth paragraph of our March 11, 1994 Order on Review, and we substitute the following.

Because claimant's current neck condition did not arise directly from her April 1991 work injury, the current condition is best characterized as a claim for a consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Therefore, in order to establish compensability of her current neck condition, claimant must prove that her original low back injury is the major contributing cause of the current condition. Kephart v. Green River Lumber, 118 Or App 76, 79 (1993); Albany General Hospital v.Gasperino, supra.

Here, Dr. Anderson, claimant's treating physician, prescribed physical therapy as conservative treatment for her compensable low back condition. (Ex. 2-3; Tr. 7-8). There is no evidence that such treatment was prescribed for any condition other than the compensable low back injury, or that the treatment was unnecessary, unreasonable or otherwise inappropriate. Shortly after completing her physical therapy regimen in May 1992, claimant developed neck and right shoulder pain. (Tr. 9-12).

Dr. Anderson explained that claimant's underlying cervical spondylosis, which had previously been asymptomatic, was irritated by the exercise regimen, which in turn caused the nerve root to swell and become impinged upon. (Exs. 63, 65-9). Dr. Collada, consulting neurosurgeon, provided a similar description of the mechanism of injury. (Exs. 56-2, 60). Because the physical therapy exercises were the major cause of the nerve root swelling, Dr. Anderson opined that claimant's 1991 work injury was the major contributing cause of her current neck and right arm condition. (See Exs. 54-1, 65-16). There is no contravening medical opinion regarding the causal relationship between claimant's 1991 work injury and her current neck and right arm condition.

Accordingly, based on Dr. Anderson's opinion, we find that the April 1991 compensable low back injury is the major contributing cause of claimant's current neck condition. See George Hames, Jr., supra; Rosa L. Sulffridge, 45 Van Natta 1152 (1993). Therefore, we affirm the Referee's order setting aside the insurer's February 17, 1993 denial.

Accordingly, on reconsideration, as corrected and supplemented herein, we adhere to and republish our March 11, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 2, 1994 Cite as 46 Van Natta 1078 (1994)

In the Matter of the Compensation of
LEOLA M. JOHNSON, Claimant
WCB Case No. 93-14183
ORDER OF DISMISSAL
Francesconi & Busch, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

On April 5, 1994, we acknowledged a request for Board review of Referee Hazelett's March 24, 1994 order. On further examination of this record, we conclude that our acknowledgment letter was issued in error. We base this conclusion on the following reasoning.

The request for Board review which we acknowledged as an appeal in this case was actually a self-insured employer's request for Board review of Referee Baker's March 18, 1994 order in John J. Johanson, WCB Case No. 93-10812. That request was received on April 4, 1994. No request from either party for Board review of Referee Hazelett's March 24, 1994 order has been received.

In light of such circumstances, we withdraw our April 5, 1994 acknowledgment letter as erroneously issued. Inasmuch as no request for Board review of Referee Hazelett's March 24, 1994 order has been filed within 30 days of its issuance, the Referee's order has become final. ORS 656.289(3). Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH H. GREEN, Claimant
WCB Case No. 93-06993
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Hazelett's order that dismissed his request for hearing, concerning penalties and related attorney fees, for lack of jurisdiction. On review, the issue is jurisdiction. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee found that, since claimant's request for hearing only concerned entitlement to a penalty for the SAIF Corporation's allegedly unreasonable failure to pay temporary disability benefits, the Director had exclusive jurisdiction under ORS 656.262(10). We disagree.

Claimant initially requested a hearing contending that he was entitled to a penalty and related attorney fee for improper claims processing. At hearing, without objection, claimant amended his hearing request to include the issue of temporary disability benefits due under the Determination Order. See OAR 438-06-031. SAIF stipulated on the record that claimant was entitled to the one day of temporary disability benefits awarded by the Determination Order and agreed to pay those benefits. (Tr. 3). The Referee had the authority to approve this agreement on the oral record. See OAR 438-09-001(3).

While this issue was ultimately settled by the parties without being expressly addressed by the Referee, it was placed in issue by claimant's amended hearing request. Because the Referee had jurisdiction to enforce the Determination Order, he also had jurisdiction to award penalties and attorney fees related to unpaid and untimely paid temporary disability benefits. See Marie E. Brewer, 45 Van Natta 815 (1993) (Hearings Division has jurisdiction over penalty and related attorney fee issue where the claimant also raises issue of enforcement of a Determination Order).

This case is distinguishable from Ronald A. Stock, 43 Van Natta 1889 (1991), on which SAIF relies. In Stock, at the hearing, the claimant had withdrawn his request for hearing concerning the compensability issue, leaving penalties as the sole issue before the Referee. We found that, since the sole issue before the Referee was penalties pursuant to ORS 656.262(10), the matter was within the exclusive jurisdiction of the Director under that provision.

Here, by contrast, the issue of enforcement of the Determination Order was before the Referee in addition to the penalty issue. Claimant did not withdraw his request for hearing concerning that issue. Rather, the issue was settled on the record before the Referee. Therefore, the Referee had jurisdiction in this instance.

Accordingly, we reinstate claimant's request for hearing.

Penalties

The June 9, 1993 Determination Order awarded one day of temporary partial disability. As of the September 10, 1993 hearing, SAIF had not paid the temporary partial disability benefits owing claimant. SAIF offered no explanation for its failure to pay the temporary disability benefits awarded by the Determination Order. Consequently, we find SAIF's failure to pay unreasonable and award claimant a penalty equal to 25 percent of the temporary partial disability awarded by the Determination Order. Claimant's attorney is awarded one-half of the penalty assessed by this order, in lieu of an attorney fee. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Finally, claimant contends he is entitled to a penalty-related attorney fee for SAIF's allegedly unreasonable failure to pay temporary disability benefits following the reclassification of his claim. Claimant presents no evidence on what amounts, if any, were due him at that time. Accordingly, claimant has not established that SAIF's conduct was unreasonable and we decline to grant a penalty-related attorney fee.

ORDER

The Referee's order dated September 13, 1993 is reversed. Claimant's request for hearing is reinstated. Claimant is awarded a penalty equal to 25 percent of the temporary partial disability compensation awarded by the June 9, 1993 Determination Order, to be equally divided between claimant and his attorney.

June 6, 1994 Cite as 46 Van Natta 1080 (1994)

In the Matter of the Compensation of
DONNA J. BALL-GATES, Claimant
WCB Case No. 93-06155
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Michael V. Johnson's order that: (1) denied claimant's request to continue the hearing in order to obtain additional evidence from the medical arbiter; and (2) affirmed an Order on Reconsideration that awarded claimant 2 percent (3.84 degrees) scheduled permanent disability for a 1990 right arm injury. On review, the issues are continuance, evidence, and extent of scheduled permanent disability.

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

Claimant contends that the Referee erred in denying her request to continue the hearing in order to cross-examine the medical arbiter or to obtain further evidence from the medical arbiter by some other means. We disagree.

Inasmuch as ORS 656.268(6)(a) refers to "any medical arbiter report," the admissibility of testimony from or a deposition of a medical arbiter is questionable. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). We need not address this question, however, as the admissibility of such testimony or deposition is not squarely before us.

A Referee may continue a hearing for any reason that would justify postponement under OAR 438-06-081. See OAR 438-06-091. As the language of OAR 438-06-091 is permissive, the authority to continue a hearing rests within the Referee's discretion. See Sue Belucci, 41 Van Natta 1890 (1989). Finally, 438-06-091(2) requires a showing of due diligence if it is necessary to continue a hearing for the opportunity to cross-examine on documentary medical evidence.

Here, claimant did not present any circumstances that might justify postponing the hearing. Moreover, Dr. Brooks, the medical arbiter, issued his report on May 14, 1993. (Ex. 19). Claimant's attorney concedes that his office received a copy of that report on June 1, 1993. (Tr. 14). The hearing was not held until August 24, 1993. Thus, claimant had almost three months prior to hearing to depose Dr. Brooks or request an additional report from him.[1] Thus, claimant has not shown that further information from Dr. Brooks could not have been obtained with due diligence prior to the hearing.

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[1] We note that we have recently held that a supplemental report prepared by a medical arbiter clarifying the medical arbiter's initial findings can be considered because it constitutes "findings of a medical arbiter" rather than "subsequent medical evidence" under ORS 656.268(7). See Lorenzo Orozco-Santoya, 46 Van Natta 150 (1994).

OAR 438-06-091(2); Nina J. Butler, 46 Van Natta 523 (1994). Under these circumstances, the Referee did not abuse his discretion in declining to continue the hearing for cross-examination, deposition, or other means of obtaining further evidence from the medical arbiter.

ORDER

The Referee's order dated September 9, 1993, is affirmed.

June 6, 1994 Cite as 46 Van Natta 1081 (1994)

In the Matter of the Compensation of
NOLIA M. CLOUGH, Claimant
WCB Case No. 93-01541
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Barber's order which: (1) set aside its denial of claimant's right shoulder injury claim; and (2) assessed a 25 percent penalty under ORS 656.262(10) for SAIF's allegedly unreasonable denial. On review, the issues are course and scope of employment and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant was employed as bartender at the noncomplying employer's tavern when she injured her right shoulder restraining a participant in a fight. The injury occurred on a wheelchair ramp adjacent to the tavern. There is no dispute that the ramp was a part of the employer's premises.

The circumstances leading up to claimant's injury are clear. An off-duty employee became involved in a dispute with a customer while inside the tavern. Claimant warned the individuals, who were friends of hers, not to fight, and specifically told her co-employee to leave the premises. The employee left, but was followed by the customer, who attacked her. Claimant came from behind the bar and followed her friends outside. There, she proceeded to physically break up the fight, sustaining her right shoulder injury.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant's right shoulder injury was compensable. Specifically, the Referee found that claimant was not an active participant in the altercation, a finding that is not challenged on review. In addition, the Referee determined that the employer had acquiesced in claimant's conduct and that the claim was compensable based on the factors listed in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571 (1985). Finally, the Referee determined that SAIF's denial was unreasonable, finding that the employer was clearly aware that the claim was compensable.

Citing Patterson v. SAIF, 64 Or App 652 (1983), SAIF contends that claimant's right shoulder claim is not compensable. It asserts that, when claimant went outside the bar to physically intervene in the fight, she overstepped the boundaries of her job responsibilities, thereby rendering any injuries noncompensable. Moreover, SAIF argues that the claim is not compensable when the seven Mellis factors are applied.

Violation of Work Rules

In Patterson, the claimant sustained his injury while removing an unruly patient from the employer's premises. The claimant was specifically told of the employer's policy against transporting unwanted persons beyond the limits of the employer's property. The claimant, however, drove the patient beyond the limits of the employer's property to downtown Portland for release. There, the claimant sustained his injury while physically restraining the patient.

The claimant's deliberate disobedience of the employer's instructions notwithstanding, the court held that the claimant's injury was compensable. Patterson v. SAIF, supra, 64 Or App at 656. The court stated that the claimant was injured while executing the employer's assigned task of removing the patient from the premises. While the claimant's misconduct was deliberate, it did not involve a prohibited overstepping of the boundaries defining his ultimate job responsibilities. Rather, the court held that the claimant's misconduct only involved a violation of the method for accomplishing the assigned task. Accordingly, the court determined that the claimant's injury occurred within the scope of his employment. Id.

Here, SAIF contends that, when claimant intervened in the altercation outside the tavern, she overstepped the boundaries of her ultimate job responsibilities. SAIF defines claimant's ultimate job responsibility as to intervene verbally when a fight broke out and to call the police if that failed to remedy the situation. We decline to define claimant's ultimate job responsibility so narrowly.

It is apparent from the record that claimant was required to do more than serve drinks. Altercations were a relatively frequent occurrence in the tavern. (Ex. 12). Therefore, one of claimant's ultimate job responsibilities was to maintain order in the bar. The employer's policy for maintaining order was to have the bartender verbally warn those involved in misconduct to cease. If that did not work, then the next step was to call the police. (Tr. 68). The employer testified that claimant was aware of the policy and that she was never to come out from behind the bar to intervene in a fight. (Tr. 69, 81) It is unclear from claimant's testimony whether she was informed of the employer's policy.

This is not significant to our determination. Even if claimant deliberately violated the employer's policy of not physically intervening in fights, we find that such misconduct relates to the method of accomplishing claimant's ultimate job responsibilities, which included maintaining order in the tavern. Accordingly, inasmuch as she did not overstep the boundaries of her ultimate job responsibilities, claimant remained in the course of her employment when she physically intervened in the altercation on the employer's premises. Patterson v. SAIF, supra.

Davis v. R & R Truck Brokers, 112 Or App 485 (1992) does not compel a different result. In Davis, the claimant was specifically told to return a truck to his employer and to stop working. The claimant disregarded those instructions, continued working and eventually sustained his injury. The court held that claimant's injury was not compensable because there was substantial evidence to support the Board's finding that claimant's misconduct was more than a violation of a regulation relating to the method of accomplishing his work. Rather, claimant had overstepped the boundaries of the work he was to do for his employer. Davis v. R & R Truck Brokers, 112 Or App at 491.

Unlike the claimant in Davis, claimant here was still authorized to act on the employer's behalf when she intervened in the fight. She had not been told to stop working. Even though she acted in violation of the employer's approved method for maintaining order on its premises, claimant did not overstep the boundaries defining her ultimate work as had the claimant in Davis.

For the above reasons, we find that claimant's injury was sustained as a result of the method of carrying out her ultimate job responsibilities, rather than as a result of overstepping the boundaries of her work. Accordingly, we agree with the Referee that claimant's injury is compensable. This would be true even if we were to apply the factors in Mellis v. SAIF, supra.

Mellis Analysis

Under Mellis, the determination of whether an injury occurs in the course of employment involves the application of seven factors, no single one of which is dispositive: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission. Mellis v. McEwen, Hanna, Grisvold, supra, 74 Or App at 574.

SAIF asserts that claimant's intervention was for personal reasons, rather than for the benefit of the employer. Since the participants in the fight were no longer in the tavern, no other patrons or tavern property was at risk. Therefore, according to SAIF, claimant was serving no employment-related purpose when she attempted to break up the fight on the ramp adjacent to the bar.

However, OAR 845-06-047(2)(a) imposes a duty on an employer to prevent disorderly conduct on licensed premises and "in areas the licensee controls that are adjacent to or outside the premises." While claimant may have had personal motivations for physically intervening in the fight (Tr. 27), she was carrying out the employer's obligation to maintain order under the administrative rules governing Oregon Liquor Control Commission licensees. These rules provide that the licensee is responsible for any act or omission of an employee, such as claimant, in violating any administrative rule affecting license privileges. OAR 845-06-025. Therefore, to avoid a violation of OAR 845-06-047(2)(a), claimant had a duty to prevent disorderly conduct on the adjacent ramp. This was true regardless of her personal motivations.

The employer, therefore, did benefit from claimant's intervention in preventing disorderly conduct on its premises. Because of this, we consider the employer-benefit factor of the Mellis test as supporting compensability.

The issue of whether physical intervention in fights between patrons was contemplated is more difficult. It is clear that fights were commonplace in the tavern. However, most appeared to have resulted in verbal, rather than physical, intervention. (Tr. 86, 98, 99). The employer specifically testified that physical intervention was prohibited. (Tr. 68). The record, therefore, does not establish that physical intervention in fights was contemplated, although it is clear that maintaining order in the bar was contemplated. We consider this as a factor that weighs against compensability.

The same is true for the issue of whether this activity was an ordinary risk of, or incidental to, claimant's employment. Again, fights were frequent at the tavern, but the record does not conclusively establish that physical intervention was an ordinary risk of employment, since the record indicates that most interventions by bartenders were verbal rather than physical.

There is no dispute about the next two factors. Claimant was paid for the activity and she was injured on the premises.

With respect to employer acquiescence, the record is clear that the employer encouraged verbal, though not physical, intervention to stop disorderly conduct. The employer conceded, however, that they had physically intervened to prevent disorderly conduct. (Tr. 92, 105). In addition, there were instances where bartenders had violated, without reprimand, the employer's policy of staying behind the bar when trying to break up altercations. (Tr. 103-105). While most interventions were verbal rather than physical, we conclude that the record does demonstrate some degree of employer acquiescence. Accordingly, this factor tends to support compensability.

Finally, we find that claimant was not on a personal mission of her own. Although claimant was motivated at least in part by concern for her friends, she was furthering her employer's interests by controlling disorderly conduct on the premises in accordance with Oregon Liquor Control Commission rules.

In conclusion, weighing the factors that strongly favor compensability (such as benefit to employer, activity on employer premises, and payment for the activity) against those that do not (contemplated activity and incidental activity), we find that claimant's injury is compensable under the seven-part Mellis test. This is especially true where there is some evidence of employer acquiescence and where we have found that claimant was not entirely on a personal mission.

Penalty Issue

SAIF contends that, even if we find that claimant's injury is compensable, its denial was still reasonable. We agree.

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 Referee concluded, without explanation, that the employer was clearly aware that claimant's injury was compensable. However, we agree with SAIF that this claim involved some complex course and scope of employment issues. Moreover, we have held under similar circumstances that a denial based on employee misconduct was not unreasonable. See Judith A. Weeks, 45 Van Natta 2257 (1993).

In Weeks, the facts suggested that the claimant was injured while violating a known work rule. We concluded that the employer's denial was not unreasonable in light of the existing case law, i.e., Patterson and Davis, supra, concerning the effect of employee misconduct on the compensability of an injury suffered in conjunction with such misconduct.

Here, as in Weeks, the facts suggested that claimant violated the employer's policy by coming out from behind the bar to intervene in a dispute among patrons, and that she did so for personal, and other than work-related reasons. Under these circumstances, we are not prepared to hold that SAIF should have reasonably known that claimant's injury would be held compensable. Judith A. Weeks, supra. Therefore, we find that SAIF had a legitimate doubt regarding its liability when it issued its denial. Accordingly, we reverse the Referee's penalty assessment.

The dissent contends that SAIF should be penalized for failing to conduct a reasonable investigation of the facts before issuing its denial. The dissent might have a point, if claimant had sought a penalty on that basis, and the record had been developed accordingly. However, that is not claimant's theory of the case. Rather, claimant assumes that before issuing its denial, SAIF had uncovered all of the relevant facts from the employer's point of view (Respondent's brief, pp 11-12). Claimant argues that SAIF reasonably should have known that claimant's violation of a workplace rule under the given circumstances of this case would not preclude compensability under the law, for such a violation would constitute a mere deviation from employer policy concerning the method of performing claimant's ultimate duty. Although we have found for claimant on the merits of the course and scope question, we have concluded that SAIF's argument about the law (which is the issue here) is not unreasonable.

Since claimant has prevailed over SAIF's appeal regarding the compensability issue, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering all 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 attorney's services on review concerning the compensability issue is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 5, 1993 is affirmed in part and reversed in part. The Referee's assessment of a penalty against the SAIF Corporation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,000 for services on review, payable by SAIF.

Board Member Gunn dissenting in part.

The majority concludes that the SAIF Corporation had a legitimate doubt concerning the compensability of this claim when its denial was issued. Consequently, the majority declines to assess a penalty for an unreasonable denial. I disagree for the following reasons.

A denial is unreasonable if the carrier has no legitimate doubt as to its liability for the claim. Brown v. Argonaut Insurance Company, 93 Or App 588 (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).

Here, the record establishes that SAIF had the following information in its possession when it issued its denial of claimant's injury claim. First, SAIF had an October 26, 1992 memorandum from an investigator for the Workers' Compensation Division, Compliance Section. (Ex. 6). In that report, the

investigator relates claimant's statement that she was injured while restraining a bar patron from fighting. The patron threw claimant against a wall. Claimant further reported that she had advised her employer of the incident, but that the employer had refused to pay claimant's doctor bill due to the employer's lack of workers' compensation coverage. The report does not mention the location of the wall with which claimant collided nor does the report contain a reference to the employer's "bartender-fighting" policy.

Second, SAIF also had in its possession the Compliance Section's November 4, 1992 letter referring claimant's injury claim to SAIF for processing in accordance with law. (Ex. 7). In conjunction with this letter, SAIF had received the Department's November 4, 1992 order finding the employer to be noncomplying. (Ex. 8). Finally, SAIF had a November 6, 1992 "insurer-prepared" 801 form, which indicated that claimant had injured her right shoulder while "restraining a participant in a fight at the [employer], was thrown back against the wall." (Ex. 9). None of these materials discusses the location of the incident or the employer's "bartender-fighting" policy.

The aforementioned information apparently formed the basis for SAIF's January 15, 1993 denial, which contended that claimant's injury did not arise from her employment. (Ex. 10). Since there is no evidence that SAIF was aware of the location of the incident or that the employer had a "bartender-fighting" policy (let alone that claimant allegedly violated that policy), I can reach no other conclusion than SAIF's denial was not based on a legitimate doubt concerning the compensability of the claim. Therefore, the denial was unreasonable based on information available at the time of the denial.

At a minimum, the lack of information available to SAIF should have prompted further investigation before issuance of its denial. See Karen L. Lewis, 45 Van Natta 1079 (1993); Philip A. Parker, 45 Van Natta 728 (1993). Arguably, it could be inferred from the record that the noncomplying employer conveyed some kind of information to SAIF that resulted in issuance of the denial.[1] However, even if that occurred, SAIF still should have documented that it had conducted a reasonable, independent investigation to determine the circumstances of the injury before denying the claim. See OAR 436-60-140(1); 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).

Even assuming that SAIF did receive information from the noncomplying employer before issuing its denial, I would consider such information offered by an employer already found in violation of the law to be suspect and subject to independent corroboration. Since there is no indication that SAIF conducted a reasonable independent investigation to obtain such corroboration, I would still find the denial to have been unreasonable.

Because the majority does not actually evaluate the reasonableness of SAIF's denial based on the information available at the time of the denial, and because it does not require a reasonable investigation before issuance of such a denial, I respectfully dissent from that portion of the decision which declines to assess a penalty for an unreasonable denial.

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[1] That inference is acknowledged in claimant's brief. That argument is not sufficient to constitute evidence of legitimate doubt, nor should the majority treat it as a concession by claimant.

In the Matter of the Compensation of
JOSEPH D. KELLER, Claimant
WCB Case No. 93-06216
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Mills' order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's low back injury. In its brief, the self-insured employer objects to the Referee's admission of Exhibits 20A, 20B and 20C. In his reply brief, claimant objects to the Referee's admission of Exhibit 21. On review, the issues are evidence and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On January 17, 1992, claimant sustained a compensable low back injury. A November 13, 1992 Determination Order closed the claim, finding claimant medically stationary on October 19, 1992 and awarding no unscheduled permanent disability. Claimant requested reconsideration, disagreeing with the rating of disability, but not objecting to the impairment findings by his attending physician. No medical arbiter was appointed. A May 21, 1993 Order on Reconsideration affirmed the Determination Order in all respects.

On June 22, 1993, Dr. Hickethier, who was not claimant's attending physician at the time of claim closure, referred claimant to physical therapy for evaluation and treatment for worsened low back pain. (Ex. 20A).

On June 24, 1993, a physical therapist performed an examination and evaluation and indicated that claimant's pain symptoms "were of a chronic nature." (Ex. 20B).

On July 21, 1993, Dr. Freeman, claimant's attending physician, opined that claimant's compensable injury was the cause of claimant's current inability to return to work. He supported his opinion by quoting from page 2 of a September 25, 1992 physical capacities examination. (Ex. 20C).

On July 21, 1993, Dr. Hickethier opined that claimant's current low back treatment was not related to claimant's injury. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee admitted Exhibits 20A, 20B and 20C over the employer's objection and Exhibit 21 over claimant's objection. Each exhibit was generated after the issuance of the Order on Reconsideration. Citing Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993), the employer contends that no evidence subsequent to a medical arbiter's report can be admitted at hearing, including claimant's testimony. We disagree.

The employer's reliance on Pacheco-Gonzalez, supra, is misplaced. The holding in that case construes ORS 656.268(7), which prohibits the admission of medical evidence developed after the medical arbiter's report. Inasmuch as no medical arbiter was appointed here, the prohibition against admission of medical evidence subsequent to the findings of a medical arbiter does not apply to prevent these exhibits from being admitted into the record at hearing. ORS 656.268(7); Scheller v. Holly House, 125 Or App 454 (1993); Gary C. Fischer, 46 Van Natta 60, 61 (1994); on recon 46 Van Natta 221 (1994). Thus, the Referee correctly admitted the documents. However, our inquiry does not end here.

The referee must evaluate a worker's permanent disability as of the time of the reconsideration order. ORS 656.283(7); 656.295(5); Fischer, supra. Findings concerning the worker's impairment can be made only by the medical arbiter, the attending physician at the time of claim closure, or another physician's findings if concurred in by the attending physician. ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994); Dennis E. Connor,

43 Van Natta 2799 (1991); Alex J. Como, 44 Van Natta 221 (1992). Where admissible medical evidence does not address a worker's condition at the pivotal "rating date," it must be determined to be relevant in order to be considered in the evaluation of a worker's permanent impairment. Fischer, supra.

Exhibits 20A, 20B, and 21 were authored by physicians other than claimant's attending physician at the time of claim closure. In addition, none of these reports were ratified by the attending physician. Therefore, we do not consider them in our evaluation of claimant's permanent impairment. ORS 656.245(3)(b)(B); Koitzsch, supra; Fischer, supra. However, we do not reach the same conclusion with regard to Exhibit 20C.

Exhibit 20C is a July 21, 1993 letter by Dr. Freeman, claimant's attending physician at the time of claim closure, reviewing the September 25, 1992 (pre-reconsideration) physical capacities report (Ex. 10). He opined that claimant's injury was the cause of claimant's inability to return to work at the time of claim closure, supporting his opinion by quoting from page 2 of the report. There is no evidence that claimant was seen by Dr. Freeman subsequent to the Order on Reconsideration. Furthermore, the letter indicates that Dr. Freeman was addressing claimant's condition as of the date of claim closure. Gary C. Fisher, supra. In addition, Dr. Freeman also addressed the causal relationship between the compensable injury and the permanent impairment, which is necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5). See Frank H. Knott, 46 Van Natta 364 (1994). Consequently, we conclude that Exhibit 20C is relevant and should be considered.

Extent of Unscheduled Permanent Disability

Applicable Standards

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C) (temporary rules adopted by the Director to address a worker's disability not addressed by the standards). OAR 436-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994). Claimant's claim was closed by a November 13, 1992 Determination Order. Consequently, the standards effective March 13, 1992, as set forth in WCD Admin. Order 6-1992, apply.

Disability Rating

The Referee concluded that claimant failed to prove, by the preponderance of medical evidence, that he has a chronic condition. We disagree.

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" includes the midback/lower thoracic spine (T7-T12) lowback/hips area. Former OAR 436-35-320(5).

Here, the physical capacities evaluation (PCE), with which Dr. Freeman concurred, indicates that claimant is medically stationary, meaning that he has reached a plateau of material improvement. It also found that claimant cannot perform his job at injury (gymnastics instructor) because of his compensable injury. Consistent with the results of the PCE, Dr. Freeman opined that claimant is unable to meet the physical demands of his job because he is unable to repetitively bend and reach overhead, is unable to demonstrate boxing or gymnastic moves, and is unable to safely spot gymnasts. Dr. Freeman made it clear that he understands the meaning of "medically stationary" and he believes that claimant cannot return to his job because of his condition. (Exs. 16B and 20C).

The insurer, citing Lori E. Collins, 45 Van Natta 1797 (1993), contends that Dr. Freeman's concurrence in a physical capacities evaluation is insufficient to carry claimant's burden of proving that he has permanent impairment. Collins is inapposite. In Collins, we concluded on the facts of the case that there were reasons not to defer to the treating doctor's opinion. We did not categorically conclude

that in every circumstance a treating doctor's concurrence in a physical capacities evaluation would be insufficient to carry claimant's burden of proving permanent impairment. Here, the employer's doctors examined claimant and found no impairment. Subsequent to this examination, Dr. Freeman requested a job analysis and a physical capacity evaluation to determine whether claimant could return to his job at injury. Upon completion of the PCE, and in the presence of the claims adjuster, it was determined that claimant was not able to return to his previous job.

We consequently conclude that Dr. Freeman's opinions, when read together, establish that claimant is unable to repetitively use a body area due to a chronic and permanent medical condition. Former OAR 436-35-320(5); Donald E. Lowry, 45 Van Natta 1452 (1993) (the rule requires medical evidence of, at least, a partial loss of ability to repetitively use the body part). 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).

Turning to the other non-impairment factors, claimant was under 40 at the time of determination. He is entitled to a value of 0. Former OAR 436-35-290(2).

With regard to education, claimant has completed high school. The value of 0 is allowed for formal education. Former OAR 436-35-300(1), (2) and (3). The occupation assigned the highest SVP met by claimant based on the jobs he performed during the ten years preceding the time of determination is as an instrumental musician. Former OAR 436-35-300(3). This occupation is assigned an SVP rating of 8, entitling claimant to a value of 1. DOT 152.041-010; former OAR 436-35-300(3)(e). Therefore, claimant is entitled to a value of 1 for the education factor. Former 436-35-300(6).

Under the applicable standards, the adaptability factor is based on a comparison of the prior strength demands of the worker's job at the time of injury with the worker's maximum RFC at the time of determination. Former 436-35-310(1). The requirements listed in former 436-35-300(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the SVP category assigned by the DOT.

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 the job he was actually performing at the time of his injury in determining the proper DOT code to be assigned to his job. See James P. Birdwell, 46 Van Natta 380 (1994); William L. Knox, 45 Van Natta 854 (1993) (In determining the proper DOT job description, the Board considers the record as a whole, as it relates to job duties as well as strength demands to find the position which appropriately describes claimant's job at injury).

Claimant's job at injury included occasional lifting and carrying of 65 pounds, continuous standing, frequent bending and reaching. Ex. 9. We conclude that Sports Instructor (DOT 153.227-018) most appropriately describes the prior strength demands of claimant's job at injury. Claimant is unable to return to his job at injury. He is restricted to occasional lifting of 35 pounds and frequent lifting of 15 pounds or less, which is between light and medium strength. He also has restrictions on bending, reaching, and lifting overhead. For a worker who has an RFC established between two strength categories and who also has restrictions, the next lower classification shall be used. Former OAR 436-35-310(4). Consequently, claimant's RFC is light. The job of Sports Instructor is classified as medium. See DOT 153.227-018. Accordingly, claimant is entitled to a value of 3 for adaptability. Former OAR 436-35-310(3).

We now assemble the factors to determine claimant's permanent disability. Adding the age (0) and education (1) factors results in a value of 1. Former OAR 436-35-280(4). That value is then multiplied by the adaptability factor of 3, resulting in a value of 3. Former 436-35-280(6). That product is then added to the impairment value of 5, resulting in an award of 8 percent unscheduled permanent disability under the standards.

ORDER

The Referee's order dated August 31, 1993 is modified in part and affirmed in part. Claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The employer's request to offset its overpayment of $144.24 against unpaid permanent disability is approved.

Board Member Haynes dissenting.

The majority awards permanent disability based on medical evidence that claimant is unable to meet the physical demands of his job because he has a chronic condition in that he is unable to repetitively bend and reach, is unable to demonstrate boxing or gymnastic moves, and is unable to safely spot gymnasts. I disagree for the following reasons.

All physical impairment ratings shall be established on the basis of objective medical evidence supported by objective findings. OAR 436-35-320(1). 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. OAR 436-35-320(5). A "body area" means the cervical/upper thoracic spine/shoulders area and the lower thoracic spine lowback/hips area. Chronic conditions in the middleback are considered a part of the lowback/hips body area. Furthermore, there must be medical evidence of, at least, a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 1452 (1993).

Here, even though claimant cannot perform his job at injury, there is no objective medical evidence that claimant suffers from any permanent impairment attributable to the injury. Dr. Freeman has documented no loss of strength, loss of range of motion, or identified a chronic and permanent medical condition affecting a particular body area. Consequently, on this record, I would affirm the Referee's opinion finding that claimant is not entitled to a permanent disability award for a chronic low back condition.

June 6, 1994 Cite as 46 Van Natta 1089 (1994)

In the Matter of the Compensation of
KATHRYN J. LOONEY, Claimant
WCB Case Nos. 93-04309, 93-04308 & 93-00885
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Beers, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband and Hall.

Claimant requests review of those portions of Referee Garaventa's order that: (1) upheld Crawford & Company's (Crawford) denial of her aggravation claim for a low back condition; and f responsibility.

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

Claimant contends that since the Referee found that her current low back condition was causally related to her compensable injury with Crawford, the Referee erred in not setting aside Crawford's responsibility disclaimer. We disagree.

Inasmuch as the Referee found that claimant's condition had not worsened beyond the waxing and waning contemplated in the last arrangement of compensation, the claimant had not established a compensable aggravation claim. In addition, since Crawford did not deny the claim in its disclaimer, the disclaimer of responsibility, pursuant to ORS 656.308(2) was not a denial. See Gamble v. Nelson International, 124 Or App 90, 94 (1993). Rather, it served only to notify claimant that the claim may be compensable against another carrier. Id. Accordingly, it was not necessary for the Referee to "set aside" Crawford's responsibility disclaimer.

ORDER

The Referee's order dated July 23, 1993 is affirmed.

Board Member Hall dissenting.

The majority affirms the Referee's conclusion that claimant did not sustain a compensable aggravation. Because I believe that claimant did sustain a worsened condition I dissent.

In order to establish a compensable aggravation claim for an unscheduled condition, claimant must prove that: (1) since the last award of compensation, he suffered a symptomatic or pathological worsening resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last award of compensation; and (3) if the last award of compensation contemplated future periods of increased symptoms, the claimant must prove that the subject worsening has been greater than the contemplated "waxing and waning." Lucas v. Clark, 106 Or App 687, rev den 312 Or 150 (1991).

At the time of the last arrangement of compensation, claimant was released to perform her regular work eight hours per day. In September 1992, at the employer's direction, claimant began working in excess of 11 hours per day and her compensable condition worsened. As a result of this worsened condition, claimant's treating physician restricted claimant to eight hours per day, but when her compensable condition further deteriorated, the doctor removed claimant from all work for 10 days. Claimant was then initially released to work for four hours per day before building back up to working eight hours.

There is no question that claimant sustained a compensable worsening which resulted in diminished earning capacity. The only issue is whether claimant's last arrangement of compensation contemplated the degree of worsening she suffered. I find that it did not.

First of all, the "last arrangement of compensation" was the Stipulation, approved in January 1991, bringing claimant's total award of permanent partial disability to 21.5 percent (Ex. 47). The stipulation did not contain a "waxing and waning" provision. See Theodore W. Kinder, 46 Van Natta 391, 393 (1994) (Where there is no evidence that award contemplated future waxing and waning, the claimant does not have to establish that the worsening was greater than contemplated). Furthermore, at the last arrangement of compensation, the medical evidence indicated that claimant could perform her work 8 hours per day. While it may have been contemplated that claimant should not work in excess of eight hours per day, I find no persuasive evidence to suggest that the award was calculated in contemplation of a period of total disability in the event claimant was required to work in excess of eight hours per day and suffer a worsening to the point she had to be taken off work. The stipulation (Exhibit 47) offers no basis to conclude that claimant was being compensated at that time for future periods of total disability.

Consequently, I would find that claimant sustained a compensable worsening resulting in diminished earning capacity which exceeded that contemplated by the last arrangement of compensation. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
DANIEL MUCHKA, Claimant
WCB Case No. 93-07531
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denial of claimant's right elbow injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

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

Claimant applied for a job with SAIF's insured (Master Design) during the week preceding June 1, 1993. After a discussion of wages with the employer (Mr. Busher), claimant understood that he was to be hired as a painter and paid $10 per hour. There was no discussion of a preemployment test. Claimant was told to return the next Monday.

Claimant returned to Master Design the following Monday, June 1, 1993. Claimant filled out an employment application and a W-2 form. Master Design also made copies of his social security card, driver's license and proof of insurance. Claimant performed no work that day, but was told to return the following day.

Claimant arrived at Master Design at 7 o'clock a.m. on June 2, 1993. He did not have his own tools. However, consistent with its routine practice for new employees on their first day of work, Master Design provided claimant with tools. Claimant was sent with a work crew to a nearby house and was put to work preparing exterior building surfaces for painting.

At approximately 11 o'clock that morning, claimant fell off the roof and was injured. Claimant completed a form 801 on June 11, 1993. The claim was denied by SAIF on June 23, 1993.

CONCLUSIONS OF LAW AND OPINION

Reasoning that claimant's injury did not occur while he was an employee, the Referee upheld SAIF's denial. In reaching this conclusion, the Referee doubted claimant's credibility. Specifically, the Referee rejected claimant's testimony because claimant's version of events conflicted with the testimony of the employer witnesses. In addition, the Referee noted that claimant was unable to remember the name of the individual with whom he interviewed, nor could he consistently recall how he originally learned of the potential employer.

We are as capable as the Referee at assessing credibility when the determination is based on the substance of the evidence. Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984); Angelo L. Radich, 45 Van Natta 45, 46 (1993). We find, based on the substance of his testimony, as corroborated by the events surrounding the "employment negotiations" and his fall, that claimant is credible. We base this conclusion on the following reasoning.

Although claimant could not remember the name of the person who interviewed him, he did identify that person by sight at hearing as the employer, Mr. Busher. (Tr. 10). Claimant testified that he was first interviewed by Mr. Busher the week prior to June 1 and at that time they discussed wages. Understanding that he was to be paid $10 per hour, claimant recalled that he was instructed by Mr. Busher to return the next Monday, June 1, to begin work. (Tr. 11).

Claimant further testified that on June 1, 1993, he reported to the employer's place of business and filled out an employment application and a W-2 form. (Tr. 10, 12). He stated that in addition to the application, Mr. Busher made photocopies of his driver's license, social security card and proof of insurance. (Tr. 10). Claimant testified that he did not begin work that day, but returned the next morning at 7 a.m. to begin work. (Tr. 4).

The employer's version of events is significantly different. Mr. Busher, the owner of the business, testified that he never hired claimant. (Tr. 23). Mr. Busher admitted that he interviewed claimant during the week prior to June 2, 1993. (Tr. 22). However, Mr. Busher denied ever receiving an employment application from claimant. Mr. Busher testified: "I have his full, entire file. We do not have an application in there." (Tr. 22). Mr. Busher admitted that "I might have told him I'd get back to him the first of the week. I honestly don't remember. I know I didn't tell him he was hired." (Tr. 23). However, Busher denied ever discussing salary with claimant. (Tr. 25).

Mr. Garcia, an employee of Mr. Busher, testified that he witnessed claimant's fall on June 2, 1993. (Tr. 54-55). Notwithstanding this confirmation of the fall, Mr. Busher stated: "I don't think he fell off the roof to the ground, no." (Tr. 37). Furthermore, Mr. Seidner, a supervisor for Mr. Busher, testified that claimant was neither sent to a worksite on June 2 nor sent home. (Tr. 46).

Notwithstanding these varying accounts of the events preceding claimant's June 2, 1993 fall, there is no genuine dispute as to the following events. Claimant reported to the employer's place of business on the morning of June 2, 1993, was provided with tools for working and was sent as part of a work crew to a nearby site where he was directed to prepare the exterior of a home for painting. (Tr. 37). At approximately 11 a.m., claimant fell off the roof of the house. (Exs. 1 & 3).

SAIF argues that claimant was not employed on June 2, but rather he was taking a preemployment test to verify his qualifications as a painter. (Resp. Br. at 3). In defense of this assertion, SAIF points out that: (1) claimant never actually received remuneration; (2) if claimant had been hired he would have reported to work on June 2 with his own tools since all the employer's employees are required to provide their own tools; (3) claimant was ignorant of both the employer's business name and the name of Mr. Busher; (4) the employer routinely administers preemployment tests; and (5) another employee who witnessed the accident contradicted claimant's testimony that he "ultimately" hit the ground after falling from the roof. (Resp. Br. 2-5).

The arguments relied upon by SAIF fail to persuade us that claimant did not suffer a compensable injury while in the course and scope of his employment on June 2. We address those arguments as follows.

To begin, we do not consider the fact that claimant apparently did not actually receive any remuneration from the employer for the services rendered on June 2 as dispositive regarding whether claimant was, in fact, an employee (i.e., it is only probative as to whether the employer considered claimant to be an employee after the work incident). The issue is whether claimant engages to furnish services for remuneration subject to the direction and control of Master Design. Claimant specifically testified that he was hired. His activities on the morning of June 2 resemble actual labor rather than any preemployment test as SAIF argues. The testimony of SAIF's witnesses indirectly corroborates claimant's testimony regarding the manner in which new employees are interviewed and hired to work. Therefore, we are persuaded that claimant was offered employment at the rate of $10 per hour.

During testimony claimant could not identify the name of the employer's company, Master Design, Inc. (Tr. 5-8). Rather, claimant testified that he applied for work at "Master Coat." Id. (In fact, "Master Coat" is a paint product used in the employer's business, Master Design). SAIF contends that this confusion combined with claimant's inability to remember Mr. Busher's name is dispositive of whether claimant had been hired. Such confusion does not prompt us to conclude that an agreement did not exist for claimant to provide services for remuneration subject to the direction and control of Master Design. The circumstances surrounding claimant's presence at the job site suggest otherwise.

Whether claimant brought his own tools to his first day of work is equally inconsequential, considering the testimony of employer's witness, Mr. Seidner:

"Q. Did he [claimant] have any tools with him?
A. No.
Q. Is that normal for someone reporting to work.
A. Reporting to work, yeah, absolutely."
(Tr. 42).

Additionally, we are unconvinced that claimant was participating in a preemployment test. Other than the unpersuasive testimony of Mr. Busher and Mr. Seidner, there is no corroborating evidence that any other job applicants were required to spend at least 3-4 hours scraping and masking to prove their qualifications as a painter. Moreover, the testimony of one employee, Mr. Garcia, demonstrates that, historically, people are paid on their first day of work.

Having resolved these arguments concerning the parties' respective version of events, we turn to an examination of the requisite burden of proof to establish the compensability of claimant's injury claim.

In order to establish compensability of his claim, claimant must prove that an injury arising out of and in the course of employment was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Coverage under the Workers' Compensation Law extends only to those persons who are defined as a "worker" by statute. The relevant portion of ORS 656.005(28) provides:

"'Worker' means any person . . . who engages to furnish services for a remuneration, subject to the direction and control of an employer . . ."

This is a two-prong test requiring that claimant: (1) furnish services for remuneration; and (2) be under the direction and control of the employer. See Dykes v. SAIF, 47 Or App 187, 190 (1980).

For the reasons previously expressed, we are persuaded that claimant was under the control of the employer when he was told to join the crew preparing the house to be painted, and he was provided tools to do so. Therefore, claimant's status as a worker on June 2, 1993 hinges upon whether he was furnishing services for renumeration or was merely participating in a preemployment test. See BBC Brown Boveri v. Lusk, 108 Or App 623 (1991); Dykes v. SAIF, supra.

In support of its contention that claimant was not furnishing services for remuneration, SAIF relies on the reasoning expressed in Lusk and Dykes. We find each case to be distinguishable.

In Dykes, the claimant broke his leg while taking a mandatory agility test to qualify for the position of deputy sheriff. The agility test was required of all job applicants. In determining that the claim was not compensable, the Dykes court held that the mere possibility of future employment did not qualify as remuneration.

Here, even assuming that claimant's activities of June 2 were part of a uniform preemployment test, claimant's activities were a direct benefit to the employer. Specifically, the employer was preparing a house to be painted and to this end claimant spent nearly four hours scraping paint. Not only was claimant under the direction and control of Master Design, but, as confirmed by an employee (Garcia), Master Design traditionally paid its employees for their first day of work - without a preemployment test. (Tr. 54). Therefore, the remuneration element is present regardless of how Master Design chooses to characterize claimant's activities on June 2.

Significantly, in Dykes, the court stated:

> "While there are no doubt decisions holding that an employe who is injured while engaged in preemployment training is subject to the control of the employer, he is nevertheless performing services for the employer, mainly, receiving training for the future benefit of the employer." Dykes, 47 Or App at 190.

The present case is analogous to the court's hypothetical in Dykes. However, rather than the employer receiving training as a future benefit, the employer was receiving the more tangible and immediate benefit of direct labor. In other words, we are not persuaded that claimant was mistaken in his belief that he was to be remunerated for the services he furnished on June 2, 1993.

The second case, BBC Brown Boveri v. Lusk, supra, reaffirms our preceding analysis. In that case, the claimant was found not to be providing services for remuneration when he failed a welding test and was subsequently not hired; even though his hearing loss was first discovered during this same testing period. Here, in contrast with Lusk, the testimony of claimant and the employer's witnesses persuade us that claimant was engaged in work for the benefit of the employer and that he reasonably expected to be paid for that work. (Tr. 4). It is not claimant's burden to produce his employment application as proof of employment. Rather, the circumstances surrounding claimant's pre-injury activities persuade us that he was employed at the time of injury.

In conclusion, in both Dykes and Lusk the claimants were participating in testing activities which bore no benefit to the employer other than to gauge the potential employee's qualifications for a specific position. Here, in contrast, the employer was receiving a direct benefit from claimant in that he was preparing the exterior of a home in preparation for painting, and in turn, receiving $10 per hour for his labor.

Accordingly, we conclude that the parties had agreed that claimant would provide services for SAIF's insured for remuneration subject to its direction and control. Inasmuch as claimant was injured in the course and scope of performing those services and that injury was a material contributing cause of his need for medical treatment and disability, we hold that the claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this

case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the issue of compensability is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 22, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for acceptance and processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by SAIF.

In the Matter of the Compensation of
RONALD R. NELSON, Claimant
WCB Case No. 93-06056
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Haynes

The self-insured employer requests review of that portion of Referee Peterson's order that set aside its denial of claimant's low back strain injury claim. Claimant cross-requests review of that portion of the Referee's order that declined to award claimant penalties and related attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are whether claimant's low back strain arose out of and in the course of employment, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant had been smoking before work the day of the accident. He had stopped smoking by the time he fell.

The employer knew of and did not object to the practice of some employees parking on the street and walking down the driveway to enter its work site.

CONCLUSIONS OF LAW AND OPINION

Arising Out Of and In the Course of Employment

Relying on Montgomery Ward v. Cutter, 64 Or App 759 (1983) and Willis v. State Acc. Ins. Fund, 3 Or App 565 (1970), the Referee reasoned that, because claimant's accident occurred on premises over which the employer exercised some control while claimant was on his way to work, claimant's resulting low back strain arose out of and in the course of employment. On review, the employer raises numerous arguments in support of reversal. For the following reasons, we find none of them persuasive.

Claimant was a mill worker who, on the day in question, parked his car on a public street in front of the employer's premises. The employer's premises include a building that houses the work site and an adjacent employee parking lot. A public street runs in front of the employer's premises. Both employees and the public access the employer's premises by way of a driveway that runs from the public street to the entrance to the employee parking lot. The first 31 feet of the driveway is publicly-owned. At the time, the entire driveway was badly deteriorated.

Some employees, including claimant, routinely parked on the public street, because the employer had instituted a policy prohibiting smoking on its premises. To get to work, these employees walked down the driveway to the employer's building entrance. The employer had knowledge of, but did not object to, this practice.

Claimant had been smoking before the accident. He had put out his last cigarette just as he began to walk up the driveway. While claimant was walking towards the entrance of the employer's building, he tripped and fell over an area of broken pavement on the publicly-owned portion of the driveway.

The employer argues that, under the "going and coming rule", claimant's injury is noncompensable. Specifically, the employer argues that the "parking lot" exception to the "going and coming rule" does not apply. That exception applies when a worker's accident occurs on premises owned or controlled by the employer. See Boyd v. SAIF, 115 Or App 241, 244 (1992). We disagree with the employer's argument.

Subsequent to the Referee's order, the Oregon Supreme Court issued its decision in Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). There, the Court reversed the Court of Appeals' decision, 123 Or App 122 (1993), which affirmed without opinion our prior order, William F. Gilmore, 45 Van Natta 410 (1993), which held that the claimant's knee injury that had occurred while he was entering his vehicle in the employer's parking lot arose out of and in the course of employment.

Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the Supreme Court reiterated that, to establish the compensability of an injury, the claimant must establish that it (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 366. The Court clarified that this two-part analysis applies to parking lot cases. As it explained, the "parking lot rule" establishes only the time, place and circumstances of the injury, thus satisfying the first element of the analysis. Id. at 368. To prove compensability in a parking lot case, however, the Court emphasized that the claimant must also establish that his or her injury "arose out of" the employment; viz., that there is some causal connection between the injury and the employment. Id. at 368-69.

Because our order had focused only on the first element of the analysis, the Court remanded the case to us for consideration of whether the claimant had satisfied the "arising out of" element. Reasoning that the employer's parking lot had not exposed the claimant to any increased risks beyond those encountered by anyone getting into his or her car, we concluded that claimant had failed to establish that his injury arose out of his employment. William F. Gilmore, 46 Van Natta 999 (1994) (Order on Remand).

Turning to the instant case, in light of Norpac Foods, Inc. v. Gilmore, supra, we proceed to determine whether claimant has established that his injury occurred "in the course of" his employment and that the injury "arose out of" that employment.

With respect to whether claimant's injury occurred in the course of employment, the relevant inquiry is whether the employer exercised control over the publicly-owned property on which claimant fell. Relying on dictum in Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52 (1981), the employer argues that claimant can meet his burden only by establishing that the employer exercised regular control over the publicly-owned driveway. The employer asserts that, although it occasionally hired a contractor to plow snow from the driveway, its control was "irregular and incidental to the maintenance of the employer-owned portion of the driveway." (Appellant's Brief at 9). Accordingly, the employer argues, it did not exercise sufficient control over the premises to warrant the application of the "parking lot rule." We disagree.

The dispositive issue is whether the employer exercised at least partial control over the premises at the time the accident took place. See Montgomery Ward v. Malinen, 71 Or App 457, 461 (1984); see also Cope v. West American Ins. Co., 309 Or 232, 238 (1990) (employer need only exercise "some" control over the premises); Irene F. Shattuck, 45 Van Natta 1752 (1993) (same). Year-round control is not required. Montgomery Ward v. Malinen, supra, 71 Or App at 461.

Here, the record reveals that the employer contracted for snow removal services on the entire driveway every year. There is also some evidence that the employer paid to have the driveway swept and otherwise cleaned up at various times, because the city did not clean the driveway, and that the employer's supervisor had told some employees that the employer would repair the deteriorated

pavement. Finally, there is evidence that, prior to claimant's accident, the employer had instituted a policy that banned smoking on company premises. The employer's supervisors told employees that "company premises" was defined as the area up to two telephone poles near the entrance to the driveway, which included most of the publicly-owned portion of the driveway, and the location where claimant fell.

From the record, we discern that, although it may have been exercised only intermittently, the employer assumed year-round responsibility for maintaining the entire driveway. Moreover, the employer had instituted a "no smoking" policy that prohibited smoking on most of the driveway, including the area where claimant fell, and the employer's supervisor had represented that the employer would repair the driveway. Taken together, those factors lead us to conclude that the employer exercised sufficient control over the publicly-owned portion of the driveway at the time claimant fell to bring this case within the "parking lot rule."

Citing Montgomery Ward v. Malinen, supra, and Willis v. State Acc. Ins. Fund, supra, the employer argues that claimant's claim fails, because the control that it assumed over the area where claimant fell was not directly responsible for claimant's injury. The employer misreads those cases.

In Malinen, the employee fell because the employer had failed to exercise its legal duty to remove snow and ice from a sidewalk in front of its premises. However, in its closing remarks, the court made clear that the pivotal issue was whether the employer had the right to exercise control over the premises at the time the accident took place, Malinen, supra, 71 Or App at 461, not whether the worker's injury was directly related to the nature of the employer's control.[1]

In Willis, the employee fell on a paved walkway in some "residual moisture." Willis, supra, 3 Or App at 567-68. Although the employer exercised substantial responsibility for the daily upkeep of the walkway, id. at 567, there is nothing in the case that suggests that the "residual moisture" was related to the employer's maintenance activities, much less that those activities were directly responsible for the claimant's injury. Rather, as in Malinen, the Willis court's focus was on the fact that the employer had exercised some control over the premises at the time the claimant fell. See id. at 572.

For the foregoing reasons, we conclude that the employer exercised the requisite control over the publicly-owned portion of the driveway on which claimant fell. It follows that claimant's injury occurred "in the course" of his employment. See Norpac Foods, Inc. v. Gilmore, supra.[2] We turn to the issue of whether his injury "arose out of" that employment.

As we stated earlier, to establish that an injury "arose out of" employment, the claimant must establish that there is some causal connection between the injury and his or her employment. Id. at 368-69. In a "parking lot" case, that causal connection exists when the claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercises some

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[1] In its closing paragraph, the Malinen court said:

> "Employer argues that it did not 'regularly [exercise] such control of the sidewalk where claimant fell as to make it an adjunct of the store or a part of its premises' in part because, if the injury had taken place during the summer, no court 'would conclude that the injury had arisen out of claimant's employment or was otherwise work related just from the fact that [employer] regularly removed snow and ice from the sidewalk during winter.' In Montgomery [v. State Ind. Acc. Com., 224 Or 380 (1960)], Willis and Cutter, however, each employer had the right to exercise partial control over the premises at the time the accidents took place. Year-round control was not material in those cases. Its absence is not material here." Montgomery Ward v. Malinen, supra, 71 Or App at 461 (brackets in original).

[2] The employer argues that claimant's claim fails, because claimant has not proved that his injury was caused by an increased employer-created hazard. In dictum, the court in Cope v. West American Ins. Co., supra, said, "Whether the requisite control is evinced by increased, employer-created hazards, Nelson v. Douglas Fir Plywood Co., [260 Or 53 (1971)], or by the employer's property rights to the area where the injury is sustained, Kowcum v. Bybee, [182 Or 271 (1947)], is immaterial." 309 Or at 239 (emphasis added). Because we have concluded that the employer had exercised actual control over the driveway when claimant fell, through its maintenance activities and company policies, we need not address whether the employer also manifested control over the driveway by way of an increased, employer-created hazard. See Adamson v. The Dalles Cherry Growers, Inc., supra.

control. See William F. Gilmore, supra, 46 Van Natta at 1000; see also Willis v. State Acc. Ins. Fund, supra (fall on wet pavement controlled by employer); Montgomery Ward v. Cutter, supra (fall in hole in parking lot employer had right to control); Montgomery Ward v. Malinen, supra (fall on icy pavement employer had legal duty to maintain). In other words, claimant must prove that the conditions of his employment put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333 (1994).

At hearing, claimant testified, "After I put the cigarette out I turned right to walk, and I fell, tripped and fell where the pavement is broken." (Tr. 22; see also Tr. 20). His initial emergency room report recorded that claimant had "tripped over rough pavement." (Ex. 1-1). We conclude that this evidence establishes that claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercised some control, viz., the driveway.

Moreover, the routine practice of some employees, including claimant, of parking on the street to avoid violating the employer's "no smoking" policy, the employer's knowledge of and failure to object to that practice, and the employees' use of a direct route over the driveway to enter the employer's work site establish that claimant's conditions of employment put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, supra. For these reasons, we conclude that claimant has established that his injury arose out of his employment.

Relying on Ruben G. Rothe, 45 Van Natta 369, 372 (1993), the employer argues that, because claimant did not testify that he tripped on, over, or as a result of the broken pavement, claimant's fall was unexplained and, therefore, not compensable. We disagree. In Rothe, the claimant fell at work, but was unable to testify regarding any specifics of the fall. Here, in contrast, there is testimonial and documentary evidence closely linking the crack in the pavement to claimant's fall. (See Tr. 20, 22; Ex. 1-1). Accordingly, we find that Rothe is distinguishable.

The employer also argues that claimant failed to establish that he fell because of a crack in the pavement, on the ground that "the history which claimant gave his treating physician following the fall was inconsistent with claimant's testimony at hearing." (Appellant's Brief at 6.) We disagree.

Dr. Petterson, claimant's treating physician, recorded in a transcribed chart note several weeks after the accident that claimant "was walking to his car when he slipped and fell injury his back." (Ex. 8) (emphasis added). In light of claimant's persuasive testimony at hearing, as well as the fact that all the other evidence supports claimant's testimony regarding the circumstances surrounding his fall (see Exs. 1-1, 2, 4), we conclude that Dr. Petterson's report likely misrecorded claimant's description of the circumstances surrounding the accident and, therefore, is not material to this issue.[3]

Next, the employer argues that claimant has failed to establish the compensability of his injury because he was on a personal mission when the injury occurred. That is, the employer argues, because claimant parked on the street for the sole purpose of enabling him to smoke before and after work and during his lunch break, his fall was the direct result of his pursuit of personal pleasure, and hence, under ORS 656.005(7)(b)(B), his low back strain is not compensable. Alternatively, the employer argues that any work connection was severed because, at the time of his accident, claimant was engaged in "personal comfort" activity. We disagree with both arguments.

The record reveals that claimant had stopped smoking by the time he fell. (See Tr. 13, 20). There is no evidence that claimant fell because of anything related to the physical act of smoking. Therefore, assuming, without deciding, that claimant was on a personal mission, or engaged in "personal comfort" activity, while he was smoking before work on the day of the accident, on this record, we conclude that claimant had ceased to engage in that activity by the time he fell. Accordingly, we reject the employer's personal mission and "personal comfort" arguments.[4]

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[3] Relying on Zurita v. Canby Nursery, 115 Or App 330 (1992), rev den 315 Or 443 (1993), the employer argues that claimant's hearsay statement to Dr. Petterson was not sufficient to establish the compensability of this claim. Because we have concluded that claimant's testimony regarding the nature of his fall is sufficient to establish that he tripped on the broken asphalt, we need not address that argument.

[4] The employer refers us to Boyd v. SAIF, supra, where the court said that the work connection of "going and coming" activities may be severed if the claimant was engaged in activity of a personal nature when the injury occurred. The employer argues that, because claimant was engaged in an activity of a personal nature -- smoking -- when the accident occurred, any connection between claimant's work and his actions at the time was severed. Because we have found that claimant was no longer smoking when his injury occurred, we reject the employer's argument.

Finally, the employer argues that, under the unitary work connection test, claimant's claim fails. See Rogers v. SAIF, 289 Or 633 (1980). Specifically, the employer relies on the seven-part test set forth in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 573-74, rev den 300 Or 249 (1985), and argues that claimant's injury is not compensable, because claimant's habit of smoking before work (1) was not for the employer's benefit; (2) was not contemplated by the employer; (3) was not an ordinary risk of, or incidental to, his employment; (4) was not a paid activity; (5) was not on the employer's premises; (6) was not directed by or acquiesced in by the employer; and (7) was part of claimant's personal mission. We disagree.

The employer's argument focuses on the wrong activity. Claimant's smoking habit is not at issue. Rather, the proper focus is claimant's act of walking up the driveway to work. On this record, we are persuaded that that action is sufficiently work-connected to pass muster under Mellis.

That claimant went to work was obviously for the employer's benefit, contemplated by the employer, and an ordinary risk of, or incidental to, his employment. And, although the act of going to work was not a paid activity in this case,[5] on this record, we conclude that, because employees arrived at work by automobile, on bicycle or on foot, and because the employer knew of and did not object when some employees parked on the street, the employer acquiesced in claimant's method of getting to work. (See Tr. 34, 38, 55, 57, 66).[6] Finally, we have already determined that the employer controlled the premises, and that claimant was not on a personal mission when he fell. Accordingly, we conclude that claimant has established a sufficient work connection between his injury and his employment.[7]

In sum, we conclude that claimant has established that his injury occurred in the course of and arose out of his employment. Accordingly, his injury is compensable.

Penalties and Attorney Fees -- Allegedly Unreasonable Denial

We adopt the Referee's conclusions that declined to award penalties and attorney fees regarding the employer's allegedly unreasonable denial.

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

ORDER

The Referee's order dated August 3, 1993 is affirmed. For services on Board review, claimant's attorney is awarded $2,000, to be paid by the self-insured employer.

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[5] Whether an injury is work-related is a matter to be decided on a case-by-case basis; not all seven factors of the Mellis test need be satisfied, and no single factor is dispositive. See Preston v. SAIF, 88 Or App 327, 330 (1987).

[6] The employer argues that this case is governed by Denise C. Smith, 46 Van Natta 783 (1994). We disagree. In that case, we held that a claimant's injury sustained on an employer-controlled parking lot was not compensable because the claimant was on the lot solely for her husband's convenience and because there was no evidence that the employer had acquiesced in the claimant's use of the lot. Here, in contrast, there is evidence establishing the employer's acquiescence in the common practice by some employees of parking on the street and using the driveway to access the employer's premises. For that reason, we find Denise C. Smith distinguishable.

[7] Relying on Joseph M. Edney, 43 Van Natta 163 (1991), the employer argues that claimant's injury is not compensable because he was on a personal deviation at the time of his accident. Edney directs us to analyze personal deviation questions under the seven-part test set forth in Mellis v. McEwen, Hanna, Grisvold, supra. Therefore, assuming, but not deciding, that claimant was on a deviation, because we have already determined under Mellis that claimant's injury was work-connected, we need not address the employer's argument.

In the Matter of the Compensation of
MICHAEL S. PLYBON, Claimant
WCB Case No. 93-07511
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Referee Daughtry's order which set aside its denial of claimant's current low back, mid-back and neck conditions. On review, the issue is compensability.

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

The employer argues that the Referee's finding of compensability is inconsistent with his finding that claimant is not a credible witness. It contends that Dr. Karasek's opinion that claimant's neck, mid back, low back, groin and leg pain is due to the industrial injury must be rejected because it is based on claimant's history, which is not reliable because claimant is not credible.

The Referee specifically found that claimant was not a credible witness and he viewed claimant's testimony "with caution." Nevertheless, the Referee concluded that claimant had sustained a compensable injury. The Referee said "[a]fter observing claimant at hearing, particularly his ineptness in trying to avoid admitting he had lied to Mr. Hill, I simply do not believe he is capable of fooling every doctor involved in this claim and sustaining such a deception since the injury."

The Board ordinarily defers to demeanor-based credibility findings. See Bush v. SAIF, 68 Or App 230 (1984). Even if the claimant is not a credible witness, it does not necessarily follow that he did not prove his claim. See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991); Robert E. Vanwormer, 46 Van Natta 328 (1994). If claimant lacks credibility in certain matters, he can still meet his burden of proof if the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985); Brett D. Adair, 46 Van Natta 378, 379 (1994).

Dr. Karasek, a neurologist and claimant's second treating physician, stated:

> "In my opinion, the major contributing cause of Mr. Plybon's neck pain, mid to low back pain and radiating pain in the groin and the legs is due to the injury at [the employer] in March of 1993. His testimony is consistent and he does have palpable spasm and response to spine injections that support this contention. I found this patient to be sincere and forthright." (Ex. 33).

The Referee found that claimant was not as forthright and sincere as did Dr. Karasek. However, the Referee concluded that "the injury occurred essentially as claimant said it did and Dr. Karasek opined such an accident would and did cause the continuing conditions and problems claimant has." The Referee also noted that there is no contrary medical opinion.

Notwithstanding claimant's fabrication concerning his whereabouts the day after the injury, we concur with the Referee's reasoning that the record as a whole supports the history regarding claimant's injury that forms the basis of Dr. Karasek's opinion. See Brett D. Adair, supra. Therefore, we agree with the Referee's conclusion that Dr. Karasek's opinion is based on an accurate history and establishes a compensable injury.

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

ORDER

The Referee's order dated October 21, 1993 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the self-insured employer.

June 6, 1994 Cite as 46 Van Natta 1100 (1994)

In the Matter of the Compensation of
JEFFREY B. TREVITTS, Claimant
WCB Case No. 92-13272
INTERIM ORDER
Royce, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Claimant has requested review of those portions of Referee Galton's order that: (1) found that the Hearings Division did not have jurisdiction over a dispute involving the effect of an approved Claim Disposition Agreement (CDA); and alternatively, (2) held that claimant was not entitled to further "non-medical service" benefits as a result of the CDA. The self-insured employer's prior claims processor, Continental Loss Adjusting Services (Continental) has requested review of that portion of the Referee's order which held that Continental was not a party to the proceeding.

One of the potential issues subject to our review is whether the CDA pertains to only those conditions accepted at the time of approval of the CDA or whether the CDA pertains to the release of all future "non-medical service" benefits under claimant's compensable injury claim. While proceeding with our review, we determined that this question was an issue of first impression which could have a significant impact on the workers' compensation system.

Consequently, on May 18, 1994, we notified the participants that we had concluded that the aforementioned issue in this case had satisfied the requisite criteria for granting oral argument. See Ruben G. Rothe, 45 Van Natta 369 (1993). The participants were further advised that arrangements would soon be made to schedule the time and place for the argument.

On May 20, 1994, in response to our announcement, claimant objected to Continental's participation at the oral argument. Noting that Continental's motion to intervene at the original hearing was denied, claimant argued that Continental is without standing to appear at the oral argument. Claimant does not oppose Continental's right to submit an amicus brief.

Neither Continental nor Sedgwick James (the self-insured employer's current claims adjusting agent) have responded to claimant's objection. However, Continental has previously presented its arguments regarding the Referee's denial of its motion to intervene at the hearing. After fully considering this matter, we conclude that Continental is not entitled to present oral argument. Our conclusion is based on the following reasoning.

"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). Although not a "party," a self-insured employer's claims processor stands as the functional equivalent of an insurer. See Martin N. Manning, 40 Van Natta 374 (1988).

Here, the self-insured employer has employed two claims processing agents. Continental was the claims processor at the time claimant and the employer entered into the CDA. The present dispute (i.e., the employer's refusal to pay temporary disability after claimant underwent surgery for a "consequential condition") arose after Sedgwick James became the employer's claims processor.

Inasmuch as Continental is a claims processing agent, it is not a "party." See ORS 656.005(20). Moreover, since Continental was not the self-insured employer's claims processing agent at the time the present dispute arose, we conclude that it is not the functional equivalent of a "party." That designation belongs to Sedgwick James, the employer's current claims processing agent at the time of hearing. Thus, counsel for Sedgwick James is entitled to present the employer's position at the upcoming oral argument.

Under such circumstances, we hold that Continental is not entitled to present oral argument. Nevertheless, considering Continental's prior involvement during the negotiations which led to the execution of the CDA, we recognize that it has a specific interest in this dispute. Therefore, in the event that Continental wishes to submit supplemental written argument regarding the issue presented for oral argument, we will consider that written argument as an amicus curiae brief. However, consistent with the supplemental briefing schedule established in our May 18, 1994 "oral argument" announcement, all written arguments (including amicus briefs from any interested organization) must be filed on or before June 15, 1994.

Accordingly, oral argument has been scheduled for Wednesday, June 29, 1994 at 1:30 p.m. in a hearing room at the Board's Salem office. At that time, claimant and Sedgwick James on behalf of the self-insured employer shall present their oral arguments concerning the issue we have previously identified for consideration. Once the oral arguments are concluded, we will continue with our deliberations.

We retain jurisdiction over this case. This order is interim and will be incorporated into our eventual final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD J. VELASQUEZ, Claimant
WCB Case No. 93-01584
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Mongrain's order that: (1) upheld the insurer's denial of claimant's bilateral hand condition; (2) declined to award a penalty for an allegedly unreasonable denial of vocational assistance; and (3) assessed a penalty of 5 percent for allegedly unreasonable claims processing. On review, the issues are scope of the denial, compensability, and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of the Denial

Claimant has an accepted claim for bilateral carpal tunnel syndrome. Following surgery, claimant sought further treatment from his treating physician, Dr. Townsend, orthopedic surgeon, for bilateral wrist pain and hand numbness. The insurer eventually issued a denial stating that it had "received recent medical information which shows that your current complaints are related to ulnar nerve complaints." (Ex. 21). The letter further stated that the insurer was "not accepting responsibility for your bilateral ulnar symptoms or any related treatment including vocational rehabilitation" but that it would "continue to pay for treatment as long as it is related to your [accepted] bilateral carpal tunnel[.]" (Id.)

Claimant asserts that the insurer's denial is for his "current condition" while the insurer argues that the denial is for "ulnar symptoms only." The express language of the denial controls the scope of conditions denied. See Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993); Pamela S. Cheney, 44 Van Natta 1137, 1139 (1992). Based on the language of the insurer's denial, we agree with claimant.

Because the letter stated that claimant's "current complaints" were related to "ulnar nerve complaints," we find that the letter's references to the ulnar nerve were merely the insurer's own description of claimant's entire current condition. In view of this finding, we conclude that the denial of "bilateral ulnar symptoms" is most reasonably construed as a denial of the compensability of claimant's current condition rather than a denial limited to only those symptoms attributable by the physicians to the ulnar nerve. We proceed to compensability.

Compensability

Following carpal tunnel surgery, claimant's symptoms initially improved, (Exs. 9, 11), with subsequent recurrence of hand pain and numbness. In September 1992, at the insurer's request, claimant was examined by Dr. Gabr, neurologist, and Dr. Dinneen, orthopedist. The panel found "[r]ecurrent symptoms of pain and numbness in the hands following carpal tunnel release surgery" without substantiation "by abnormal objective findings on examination." (Ex. 13-3). The panel also indicated that claimant did not "appear to have motor/sensory deficit or other signs on examination * * * consistent with carpal tunnel syndrome." (Id. at 4).

Dr. Townsend agreed with the panel's "assessment and recommendations" but withheld his opinion regarding medically stationary status pending an examination by Dr. Grant, physical medicine and rehabilitation specialist, to determine "whether or not there is a recurrence of the carpal tunnel syndrome or an involvement of some other nerve compressive neuropathy." (Ex. 14).

Dr. Grant described claimant's symptoms as "pain in the volar ulnar wrist region" and "numbness and tingling in the fourth and fifth fingers." (Ex. 15-2). Based on electrodiagnostic testing, Dr. Grant found minimal right ulnar neuropathy at the elbow and no such neuropathy on the left. (Id.) Dr. Grant also found some evidence of abnormalities in the median nerve, but classified them as "residual" rather than "ongoing median neuropathy." (Id. at 2-3).

Based on Dr. Grant's report, Dr. Townsend reported that "the ulnar symptoms are probably not related to the carpal tunnel syndrome or related to his work activities." (Ex. 17).

At Dr. Townsend's request, Dr. Pons, hand surgeon, also examined claimant. Dr. Pons referred to claimant's symptoms as "intermittent numbness over the ulnar distribution of both hands, * * * pain on the radial half of his wrist, and recent development of locking of the right thumb." (Ex. 16). Dr. Pons found that claimant was "suffering from overuse-type syndrome." (Id.) Dr. Townsend subsequently informed the insurer that claimant's complaints were "not those commonly associated with carpal tunnel syndrome" but were "more related to ulnar nerve symptoms, as well as ill-defined pain and tenderness about his wrist level." (Ex. 19). With regard to the development of an overuse syndrome, Dr. Pons indicated that it was "not unusual after developing the types of symptoms that [claimant] has to continue these symptoms even after he stops [working]." (Id.)

After the insurer issued its denial, Dr. Townsend reported to the insurer that claimant's "complaints at this point seem to be more in the ulnar nerve distribution, but he also complains of some pain in the area of the carpal tunnel incisions." (Ex. 22). Dr. Townsend also expressed difficulty in determining "exactly what is causing [claimant's] ongoing symptoms." (Id.)

Dr. Gabr then concurred with a report written by the insurer's attorney stating that, based on his examination and medical reports generated subsequent to the examination, claimant's "symptoms would be primarily ulnar in nature" and "unrelated to [claimant's] carpal tunnel syndrome." (Ex. 23-1). The report further indicated that Dr. Gabr had found no evidence of ulnar symptoms during his September 12, 1992 examination of claimant. Dr. Gabr therefore found that the symptoms arose after the examination so they "could not possibly be related to the work duties that [claimant] was performing in 1990." (Id. at 2).

Dr. Townsend's final report indicated that his "present diagnosis" was "status post bilateral carpal tunnel releases with some residual carpal tunnel syndrome and overuse syndrome of both wrists." (Ex. 25). Dr. Townsend attributed claimant's "present conditions" to claimant's "previous work activities." (Id.)

There is evidence that claimant has some "residual" carpal tunnel syndrome, as Dr. Townsend diagnosed. Notwithstanding this diagnosis, we find that the preponderance of evidence establishes that claimant's need for treatment is not due to his accepted carpal tunnel syndrome. First, it appears that Dr. Townsend's diagnosis of "residuals" of carpal tunnel syndrome was based on Dr. Grant's report that claimant had "residuals" of carpal tunnel syndrome. However, Dr. Grant's impression was made in the context of explaining abnormality in the median nerve which appeared in electrodiagnostic testing. Dr. Grant did not relate any of claimant's symptoms to a "residual" condition. Similarly, Dr. Townsend did not explain which symptoms, if any, were attributable to residual carpal tunnel syndrome.

Furthermore, Dr. Pons persuasively explained why claimant's symptoms were not of the type associated with carpal tunnel syndrome, finding that they were more properly characterized as being related to the ulnar nerve. That opinion was supported by Dr. Gabr.

Finally, in an earlier report, Dr. Townsend also indicated that claimant's complaints were attributable to the ulnar nerve, with some pain in the area of his incisions from surgery. We find this report to be further support for our finding that claimant's need for treatment was not related to his carpal tunnel syndrome.

We agree with the Referee that claimant failed to prove the compensability of his current disability or need for treatment. First, we find persuasive reasons not to defer to Dr. Townsend's most recent report attributing claimant's condition to work activities since it was contradicted by an earlier report by him that claimant's ulnar symptoms were not related to claimant's employment. See Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, we do not find persuasive Dr. Pons' opinion that claimant had an overuse syndrome as a result of work activities. See Somers v. SAIF, 77 Or App 259 (1986). We agree with the Referee that Dr. Pons assumed, in error, that the onset of claimant's ulnar symptoms occurred while he was working. According to Dr. Gabr, who examined claimant after he underwent carpal tunnel surgeries and had been off work for approximately nine months, claimant did not exhibit any symptoms related to the ulnar nerve at the time of his examination. Furthermore, the record contained no mention of ulnar nerve-related complaints until October 1992, when claimant had been off work for approximately ten months.

There is no other medical opinion supporting a causal relationship between claimant's current condition and either his work activities or accepted condition. Consequently, we conclude that claimant failed to prove compensability of his current bilateral hand condition. See ORS 656.005(7)(a), 656.005(7)(a)(A), 656.802(2).

Penalties

Claimant further asserts that the "portion of the Insurer's denial which purports to deny vocational rehabilitation services is void" because it does not conform with the rules for properly denying vocational assistance. According to claimant, he is entitled to a penalty because the insurer "utilized the wrong procedure."

The denial letter stated that the insurer was "not accepting responsibility for your bilateral ulnar symptoms or any related treatment including vocational rehabilitation" but that it would "continue to pay for treatment as long as it is related to your bilateral carpal tunnel[.]" We have construed the denial as concerning claimant's current condition. Inasmuch as we have also concluded that claimant's current need for treatment is not compensable, we find no "amounts then due" upon which to base a penalty. See ORS 656.262(10).

We further note that, in view of the denial's affirmation of the compensability of claimant's accepted carpal tunnel syndrome and our conclusion that claimant's current need for treatment did not relate to the accepted condition, we find that the letter's denial of vocational assistance is not for any such vocational services benefits that claimant may be eligible for based on his accepted carpal tunnel syndrome. Therefore, we do not find any unreasonable resistance to the payment of compensation to support the award of an attorney fee under ORS 656.382(1).

However, we agree with claimant that he is entitled to a 10 percent penalty for the insurer's late payment of benefits. There is no dispute that the insurer's payment of permanent disability was not timely and it offers no reasonable explanation for its action.

ORDER

The Referee's order dated June 18, 1993, as amended on June 25, 1993, is affirmed in part and modified in part. In lieu of the Referee's award of a 5 percent penalty for an unreasonable delay in payment of benefits, claimant is awarded a penalty equal to 10 percent of the permanent disability awarded by the February 11, 1993 Determination Order, to be shared equally by claimant and his counsel. The remainder of the order is affirmed.

June 7, 1994 Cite as 46 Van Natta 1104 (1994)

In the Matter of the Compensation of
SARAH E. ASHER, Claimant
WCB Case No. 93-02474
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee T. Lavere Johnson's order that set aside its "back-up" denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issues are "back-up" denial and, potentially, compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Credibility

We adopt those portions of the Referee's Conclusions of Law and Opinion that determined, based on demeanor, that claimant was a credible witness, and that Mr. Peters (claimant's ex-husband) is not a credible witness. We defer to these findings because of the Referee's opportunity to observe the witnesses. See Humphrey v. SAIF, 58 Or App 360 (1982).

We do not adopt the remainder of the Referee's conclusions under the "credibility" portion of his opinion and order.

"Back-up" Denial

Once two years has passed from the date of accepting a worker's claim for compensation, the insurer may not thereafter deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. See ORS 656.262(6); Anthony G. Ford, 44 Van Natta 239 (1992). A retroactive, or "back-up," denial of a previously accepted condition will be upheld if the insurer can prove that the fraud, misrepresentation or other illegal activity alleged could have "reasonably affected" the insurer's original decision regarding the compensability of the claim. Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987) (The Supreme Court held that the measure of materiality for the purpose of justifying a "back-up" denial was a showing by the insurer that it would have denied the claim had it known about the undisclosed information.); cf. Liberty Northwest Insurance Corp. v. Salyers, 91 Or App 538 (1988) (Where the claimant subsequently admitted an off-the-job incident, but maintained that his injury initially occurred at work, the court found that the carrier had failed to sustain its burden of proof that the claimant's misrepresentations could have reasonably affected its decision to accept the claim.); but see: Newport Elks Club v. Hays, 92 Or App 604, 607 (1988) (Where the claimant provided inconsistent histories to her treating physicians, one of which did not indicate that an industrial injury had occurred, the court upheld a "back-up" denial, reasoning: "it requires no

elaboration to conclude that employer's acceptance could have been influenced by having the information that no industrial injury had occurred.").

Therefore, the insurer's burden upon issuing a "back-up" denial is two-fold: (1) it must demonstrate that claimant's non-disclosure of her prior bilateral hand symptoms constitutes fraud, misrepresentation, or other illegal activity; and (2) it must prove that claimant's non-disclosure was sufficiently material to reasonably affect the insurer's original decision regarding the compensability of her bilateral carpal tunnel syndrome.

Here, upon filing a claim for bilateral carpal tunnel syndrome, claimant denied any previous hand problems. (Exs. 3 & 6). Claimant related this symptom-free history to the doctors who examined her (Exs. 13-2, 20-1) and to an insurance investigator. (Ex. 5A-1). The insurer argues that its claim acceptance was based on claimant's intentional misrepresentations and relies on claimant's past complaints concerning her hands, arms and shoulders, and the testimony of her ex-husband, Mr. Peters, as proof. (Tr. 55-57). Claimant asserts that her misrepresentation was unintentional since her prior symptoms were "minor, forgotten symptoms of problems which had resolved long before claimant began having serious problems related to her accepted carpal tunnel claim." (Resp. Br. at 4).

The Referee found that claimant made a misrepresentation to the insurer when she failed to disclose that she was treated for persistent numbness, tingling and "pins and needles" in both hands between 1984 and 1986. (Exs. 1-L, 1-M, 1-P, 1-Q, 27). Since claimant acknowledges that she was aware of her past complaints when she neglected to to disclose them to the insurer and her physicians, we agree that claimant's omission constitutes a misrepresentation for the purposes of issuing a "back-up" denial.

However, before the burden of proving the compensability of her bilateral carpal tunnel shifts back onto claimant, the insurer must still prove that if it had known of claimant's preexisting hand condition it would have denied her claim. See Ebbtide, supra; Salyers, supra; Newport Elks Club, supra. The Referee found that claimant's misrepresentation was not so material as to reasonably affect the insurer's decision to accept the claim. We conclude that the insurer has failed to establish that such information from claimant would have reasonably affected its claim acceptance decision.

The evidence shows that claimant had a preexisting bilateral hand condition between 1984 and 1986. Nevertheless, no diagnosis of carpal tunnel syndrome was made until after claimant's work exposure with this employer which prompted her occupational disease claim.

The insurer retains the burden of proving that the claim for bilateral carpal tunnel would have been denied if claimant's misrepresentations had been known prior to acceptance. Ebbtide, supra. The insurer argues that preexisting conditions are always relevant to the compensability of an occupational disease. (App. Br. at 12). However, the insurer fails to offer any medical opinions or other probative evidence that this particular claimant actually suffered bilateral carpal tunnel syndrome prior to 1990.

Moreover, the insurer neither offers evidence which relates claimant's past complaints as the cause of her current bilateral carpal tunnel syndrome (e.g., medical opinions), nor any evidence that, had the insurer been aware of claimant's past complaints, it would not have accepted the carpal tunnel condition (e.g., testimony of claims examiner).

The insurer contends that under Randy G. Harbo, 45 Van Natta 1676 (1993), its "back-up" denial was appropriate and shifts the burden to claimant to prove the compensability of her carpal tunnel syndrome. While the same version of ORS 656.262(6) is applicable in Harbo, the facts in that case clearly substantiated the insurer's contention that its decision to accept the claim was materially affected. In Harbo, the claimant engaged in many unrelated instances of misrepresentation and was found to be not credible. Moreover, in that case, the claimant had a preexisting diagnosed shoulder injury which was problematic up to the time of the alleged shoulder injury.

Here, unlike Harbo, this claimant was never diagnosed with carpal tunnel prior to her work exposure; her hand condition was asymptomatic for several years preceding the work exposure; and, claimant's history with regard to the onset of her current condition is persuasive. Claimant credibly

testified that the symptoms for which she sought treatment between 1984 and 1986, were unrelated in any way, other than location, from her subsequent bilateral carpal tunnel condition of 1989. (Tr. 67). More importantly, there is no medical opinion in the record rebutting this assertion, nor is there an opinion (medical or otherwise) which explains whether information of prior symptoms would have altered medical and legal conclusions that claimant's bilateral carpal tunnel syndrome was related to claimant's work activities.

Claimant argues that her case is more analogous to Ebbtide, supra. (Resp. Br. at 6). In that case, the claimant misrepresented the history of a prior back problem which had resolved several years prior to a claim for a worsening in that same area of the back. Ebbtide, supra, at page 461. The Supreme Court ruled that even if an injury claim involves the same body part as the previously undisclosed injury the burden of proving materiality remains with the insurer (i.e., the claimant never has the burden to rebut materiality). Id., at page 464.

The insurer relies upon two Board cases that were decided before the "reasonably affected" Ebbtide standard was incorporated into the Bauman test for fraud, misrepresentation or other illegal activity: (1) Leah D. Grey, 39 Van Natta 785 (1987) (claims examiner testifies that the claimant's misrepresentation was a material factor in causing the employer to accept the claim); and (2) Sharon A. Baucom, 38 Van Natta 869 (1986), (finding no practical distinction between knowingly and mistakenly misrepresenting relevant medical history, the Board held that the insurer's burden is satisfied upon showing that the "back-up" denial was justified). Since each of these holdings preceded Ebbtide, neither decision is controlling.

In conclusion, claimant's admitted failure to disclose her history of prior hand complaints before acceptance of her claim raises an "inference" that the insurer's decision to accept the claim was impacted by that omission. Nevertheless, consistent with the reasoning expressed in Ebbtide, inference is not evidence. Inasmuch as the burden of proof rests with the insurer to establish that claimant's misrepresentation would have reasonably affected its decision to accept the claim, we hold that such an inference (without supporting evidence) is insufficient to satisfy the requirement set forth in Ebbtide.

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

ORDER

The Referee's order dated September 30, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
AMY M. BOGRAN, Claimant
WCB Case No. 92-14786
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Mills' order that set aside its denial of claimant's occupational disease claim for a right hand 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

In April 1990, claimant began working as a paralegal and performed her own word processing. In July 1992, claimant sought treatment for right hand symptoms from Dr. Wilson, orthopedic surgeon, who diagnosed carpal tunnel syndrome.

In October 1992, claimant was examined by Dr. Radecki, electrodiagnostic medicine specialist, at the insurer's request. Based on "excellent" nerve conduction studies, Dr. Radecki found no evidence of median nerve pathology. (Ex. 5-3). Furthermore, according to Dr. Radecki, claimant had no objective medical condition and there was evidence of functional overlay, "suggesting that there might be some psychosomatic or psychosocial reasons for her complaints[.]" (Id.)

Although indicating that claimant "had a very mild carpal tunnel syndrome," Dr. Wilson otherwise concurred with Dr. Radecki's report. (Ex. 10). He further stated, however, that the diagnosis was "soft" since the nerve conduction tests were normal and she did not "present a typical history and presentation." (Id.) Finally, Dr. Wilson found that he could not state that claimant's work activities were the major contributing cause of her condition "since she had also been doing horseback riding intensively prior to seeing me." (Id.)

The Referee found that claimant had carried her burden of proving that her right hand condition was a compensable occupational disease. See ORS 656.802(2). In reaching this conclusion, the Referee found that the case was not a "particularly complex one" and, therefore, gave some weight to claimant's testimony, which attributed her condition to work activities. The insurer challenges the Referee's order, asserting that the case is medically complex and, in the absence of medical evidence establishing causation, claimant failed to prove compensability of her right hand condition. We agree with the insurer.

When a case involves a medically complex condition, there must be expert medical evidence establishing causation. Uris v. Compensation Department, 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 282 (1993). In determining whether a case is complex, several factors are considered, including: (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. Uris v. Compensation Department, supra, 247 Or at 276.

We find that this situation is complicated. First, her condition has not been definitively identified. Because her nerve conduction tests were normal and presentation was not typical, Dr. Wilson termed his diagnosis "soft." Furthermore, according to Dr. Radecki, claimant has exhibited some functional overlay; Dr. Wilson apparently agreed with this assessment since he disagreed only with that portion of Dr. Radecki's report finding that claimant did not have carpal tunnel syndrome. Furthermore, unlike the claimants in Uris and Barnett, claimant's symptoms have occurred in conjunction with off-work activity, such as horseback riding.

Claimant's symptoms also did not immediately appear. There was evidence that she experienced similar symptoms as early as 1989 while attending college. Following her employment as a paralegal, her symptoms progressively worsened.

Based on these reasons, we find that this case is medically complex. Therefore, there must be expert medical evidence proving that work activities were the major contributing cause of her right hand condition. See Uris v. Compensation Department, supra; Barnett v. SAIF, supra; ORS 656.802(2).

We do not agree with the Referee's characterization of Dr. Wilson's opinion as "clearly support[ing] either the horseback riding or the word processing as the probable causes of claimant's condition." Dr. Wilson stated that he "could not tell" and was "unable to say" that work activities were the major contributing cause of claimant's need for treatment. Dr. Radecki found that claimant had no medically verifiable condition. Consequently, because neither claimant's treating physician nor Dr. Radecki show that claimant's condition was caused by work activities, we find a failure of proof. Consequently, we conclude that claimant failed to prove compensability. See ORS 656.802(2).

ORDER

The Referee's order dated September 17, 1993 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
DAVID R. BRAWNER, Claimant
WCB Case No. 93-02994
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Thye's order that upheld the SAIF Corporation's partial denial of claimant's claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant does not have "Major Depression, Single Episode" (as diagnosed by Dr. Dewey, treating psychologist), and that the February 25, 1988 work injury is not the major contributing cause of whatever psychological condition claimant does have. We agree that the claim is not compensable.

Claimant need not prove the appropriateness of a particular diagnosis for his psychological problems. See Carling v. SAIF, 119 Or App 466 (1993); Tripp v. Runner Ridge Timber Services, 89 Or App 355 (1988). Rather, the question is whether claimant has established that his psychological condition (whatever the diagnosis) is compensably related to the 1988 work injury. Id.

"Under ORS 656.005(7)(a)(A), a subsequent condition is compensable if there is 'a compensable injury' and that injury is 'the major contributing cause of the consequential condition.'" Weyerhaeuser Co. v. Pitzer, 123 Or App 1, 4 (1993) (citing Kephart v. Green River Lumber, 118 Or App 76, 79 (1993); Hicks v. Spectra Physics, 117 Or App 293, 296 (1992); and Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992)); see Douglas R. Baar, 46 Van Natta 763, on recon 46 Van Natta 963 (1994).

Considering the number of potential causes for claimant's psychological problems and the passage of time since the work injury, the causation issue is a complex medical question which requires expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In evaluating causation, 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 this case, the complexity of claimant's psychological problems is undisputed. He has a passive/aggressive, passive/dependent personality disorder with explosive features. This condition preexisted the 1988 compensable back injury and manifests itself in anger, manipulation of others, social alienation, and a propensity for alcohol addiction. Claimant has been an alcoholic for most of his adult life. Alcoholism interfered with treatment for the compensable back condition and contributed to claimant's depression. In addition, claimant lost his driver's license in 1991, following a DUI conviction, and this loss contributed to his depression and complicated his return to work efforts. In sum, as of November 1992, claimant's depression, anxiety and general emotional disturbance were related to preexisting personality problems and alcoholism, rather than to the 1988 injury.

Dr. Dewey began treating claimant for his psychological complaints in February 1993. After reviewing claimant's medical history and examining him twice, Dr. Dewey noted that claimant was aware of the previous psychological findings and recommendations and "apparently is not as angry as he has been in the past." (Ex. 19-3). Dr. Dewey noted claimant's fears of unemployability, losing his home, and "decompensation" and observed that claimant "has become increasingly emotionally disturbed as time has passed[.]" (Ex. 19-3-4). However, Dewey also stated that "more recently [claimant] appears to be more accepting of his injury[.]" Although Dr. Dewey accepted the earlier diagnoses (personality problems and alcoholism) as having been "accurate," he stated that claimant's "situation has changed and his attitude has also shown considerable change as one compares his current orientation with that described in earlier psychological evaluations." (Id). Thus, Dr. Dewey concluded that claimant currently suffers from depression, "of which the major contributing cause is his injury of February 25, 1988." (Id).

Dr. Dewey expressly acknowledged the accuracy of prior psychological evaluations, which implicated preexisting causes rather than the 1988 work injury. Nonetheless, based on claimant's current attitude (perceived reduced anger and increased acceptance of the injury), Dr. Dewey opined that the 1988 back injury is now the major contributing cause of claimant's psychological problems.

In view of the nonwork-related contributing causes identified by prior examiners (particularly claimant's preexisting personality disorder), Dr. Dewey's otherwise unexplained conclusion regarding causation is not persuasive because it does not establish that claimant's longstanding contributory problems were adequately considered and explained away. Although Dr. Dewey's reasoning arguably supports his diagnosis (which focuses on a single episode, rather than a longstanding condition), without further explanation, it is not persuasive regarding the pivotal causation issue. Finally, because Dr. Dewey did not examine claimant until February 1993, almost 5 years after the work injury, he was not in a particularly good position to reliably evaluate changes in claimant's attitude.

In sum, claimant's perceived improved attitude does not reasonably suggest that the work injury caused his psychological condition. Thus, since Dr. Dewey's conclusion does not follow from his observations or reasoning, it is not persuasive. See Somers v. SAIF, supra; see also, Weiland v. SAIF, 674 Or App 810 (1983) (Board generally defers to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise). Moreover, even if Dr. Dewey's opinion was persuasive, it does not support compensability under ORS 656.005(7)(a)(A).

On June 30, 1993, after seeing claimant about ten times, Dr. Dewey observed that "when [claimant] was given the determination order and refusal of surgery, the reality of his situation hit him very hard." (Ex. 26-1). Specifically, "[t]he refusal of surgery and loss of income had a major impact on [claimant.]" (Ex. 26-2). Thus, Dr. Dewey acknowledged that claimant's primary complaints were loss of income when his claim was closed and realization that surgery is not an option.

Under these circumstances, neither claimant's reporting nor Dr. Dewey's opinion (which is apparently based on that reporting) supports a finding that the compensable injury (rather than tangential sequelae or preexisting causes) is the major contributing cause of claimant's "consequential" psychological condition. See Douglas R. Baar, supra. Accordingly, in the absence of persuasive medical evidence supporting the claim, claimant has not carried his burden under ORS 656.005(7)(a)(A).

ORDER

The Referee's order dated September 23, 1993 is affirmed.

Board Member Haynes specially concurring.

I agree with the Referee's decision to uphold the SAIF Corporation's denial of claimant's psychological condition. However, I reach this conclusion based on the following reasoning.

As noted in Member Haynes' opinion, claimant has a longstanding history of psychological problems. In light of this preexisting condition, a thorough and well-reasoned medical opinion is required to establish the requisite causal relationship between claimant's February 1988 compensable injury and his current psychological condition.

Dr. Dewey, claimant's current treating psychologist, does attribute the major contributing cause of claimant's current depression to the 1988 compensable injury. Nevertheless, in doing so, Dr. Dewey also refers to claimant's concerns regarding his lack of employment / income and the rejection of a surgery option. Such contributors do not support a conclusion that claimant's compensable injury is the major contributing cause of his current psychological condition. See ORS 656.005(7)(a)(A). Moreover, considering claimant's extensive psychological problems, Dr. Dewey does not provide a persuasive opinion explaining how claimant's compensable injury is the major contributing cause of his current psychological problems.

Lacking persuasive medical evidence supporting compensability of claimant's psychological condition, I must affirm the Referee's order. Therefore, for the reasons expressed above, I offer this special concurrence.

In the Matter of the Compensation of
ROBERT F. CURTIS, Claimant
WCB Case No. 91-07555
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Howell's order that: (1) found that claimant was precluded from raising an issue of premature closure at hearing on the ground that she had not raised that issue in her request for reconsideration; and (2) declined to award claimant permanent total disability. In its brief, the self-insured employer argues that res judicata bars claimant from litigating the premature closure issue. On review, the issues are premature closure, res judicata and alternatively, permanent total disability. We reverse.

FINDINGS OF FACT

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

Claimant requested reconsideration of a September 12, 1990 Determination Order that awarded him 31 percent unscheduled permanent disability.

The Order on Reconsideration identified the issue under reconsideration as the extent of unscheduled permanent disability. (Ex. 70). The Order on Reconsideration affirmed the Determination Order in all respects.

FINDING OF ULTIMATE FACT

On September 12, 1990, the date on which the Determination Order issued, further material improvement of claimant's low back condition could reasonably be expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

Premature Closure/Res Judicata

Relying on Cori D. Simpson, 45 Van Natta 988 (1993), and the cases cited therein, principal of which is Chester P. Schulze, 44 Van Natta 1493 (1992), the Referee concluded that claimant had waived his right to raise the premature closure at hearing because he had not specifically raised it during the reconsideration process.

Subsequent to the Referee's order, in Ruth E. Griffin, 46 Van Natta 418 (1994), we held that a claimant may raise an issue of premature closure at hearing that was not specifically raised on reconsideration. In reaching that conclusion, we disavowed Chester P. Schulze, supra, where we held that the issue of premature closure will not be considered at hearing or on review unless reconsideration was first requested on that issue. Because we have disavowed Schulze, it follows that Cori D. Simpson, the case on which the Referee relied, is no longer valid precedent regarding that issue.

Accordingly, although claimant did not raise the premature closure issue on reconsideration, in light of Ruth E. Griffin, we conclude that claimant could properly raise that issue at hearing.

The employer argues that the doctrine of res judicata precludes claimant from "relitigating" the premature closure issue. Specifically, the employer argues that, because the premature closure issue involves the same set of facts as those reviewed in an earlier Board proceeding regarding two "post-closure" denials, see Robert F. Curtis, 44 Van Natta 956, on recon 44 Van Natta 1118 (1992), under Drews v. EBI Companies, 310 Or 134 (1990), claimant's premature closure claim is barred. We need not address that argument, because we agree with claimant's assertion that the premature closure issue was not ripe prior to claimant's request for hearing on the Determination Order and Order on Reconsideration. See ORS 656.268(4)(e), (5), (6)(b); OAR 436-30-050(1) (concerning review of Determination Orders and Orders on Reconsideration). Accordingly, we reject the employer's res judicata argument.

We turn to the merits of this claim. The Referee alternatively addressed the premature closure issue and concluded that claimant's claim was not prematurely closed. For the following reasons, we disagree with the Referee's alternative conclusion.

An injured worker is considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Claimant argues that the October and November 1990 "post-closure" reports of Dr. Kendrick, neurosurgeon, establish that he was not medically stationary on September 12, 1990, the date of claim closure. Claimant's condition did not change between the September 12, 1990 closure date and November 1990.[1] Therefore, we may consider Dr. Kendrick's reports. Scheuning v. J. R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987).

Dr. Lax, claimant's then-treating neurosurgeon, declared claimant medically stable on July 20, 1990. (Ex. 49). Although the claim was closed by Determination Order on September 12, 1990 (Ex. 55), claimant continued to seek treatment for his low back symptoms. Beginning September 19, 1990, claimant consulted his family physician, Dr. Dowling, regarding his continued back problems. (See Exs. 56, 57). Dr. Dowling was unable to alleviate claimant's symptoms. (See Ex. 57). Therefore, he referred claimant to Dr. Kendrick. (See Ex. 60).

On October 18, 1990, Dr. Kendrick examined claimant. (Id.) After reviewing claimant's history, physical examination and available radiological data, Dr. Kendrick concluded that claimant's back pain

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[1] Claimant asserts that, because this Board held in Robert F. Curtis, supra, that he did not suffer an aggravation of his condition in September 1990, but was merely experiencing a waxing and waning of his back condition, as a matter of law, his condition did not change prior to Dr. Kendrick's examinations in October and November 1990. (Claimant's Appellant's Brief at 21 n.2). The employer apparently agrees with this argument. (Employer/Respondent's Brief at 6). Our review of the medical evidence persuades us that claimant's condition did not change between September and November 1990.

was largely mechanical, as opposed to compressive. (Id. at 3). He ordered a CT scan of claimant's spine and suggested that claimant possibly could respond to immobilization with internal fixation and fusion of the lower spine. (Id.)

On October 29, 1990, Dr. Kendrick saw claimant again, and reviewed claimant's CT scan. Kendrick determined that the CT scan showed facet changes at L5-6. (Ex. 62). Dr. Kendrick placed claimant in a body cast for three weeks to see whether immobilization would help claimant's pain. (See id.)

On November 20, 1990, Dr. Kendrick reported that, while claimant was in the body cast, he had experienced a dramatic decrease in pain and an increased ability to engage in physical activities. (Ex. 63-1). Based on these results, as well as claimant's history, physical examination and CT scan, Dr. Kendrick recommended surgery, stating that there was "a very high probability of [claimant] receiving significant benefit from a fusion at L5-6 together with internal fixation." (Id.)

Thereafter, on January 14, 1991, claimant was examined by Dr. Rosenbaum, neurosurgeon, on the employer's behalf. (See Ex. 64). After reviewing claimant's history and CT scan report, and performing a physical examination, Dr. Rosenbaum concluded that, because of claimant's age, symptoms and degenerative spinal condition, the surgery proposed by Dr. Kendrick was neither reasonable nor necessary. (Id. at 4). Claimant reported to Dr. Rosenbaum that, within two days after the body cast was applied, 75 percent of his pain had been relieved. (Id. at 2). However, Dr. Rosenbaum did not address that factor in his conclusions. Dr. Rosenbaum thereafter reviewed claimant's CT scan and adhered to his initial conclusions. (Ex. 65).

The opinions of both Dr. Kendrick and Dr. Rosenbaum are based on complete information; however, we find Dr. Kendrick's opinion to be the most well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986). Dr. Kendrick concluded that claimant's condition had a significant mechanical component. That conclusion led Dr. Kendrick to prescribe a body cast to determine whether claimant would benefit from a surgical immobilization of his lower spine. When the cast proved to be effective, Dr. Kendrick recommended surgery to accomplish permanently what the cast had accomplished only temporarily. We find that reasoning persuasive.

In contrast, Dr. Rosenbaum focused on claimant's history, symptoms, age and CT scan results to conclude that surgery would not be efficacious. However, although he was aware of claimant's success with the body cast, Dr. Rosenbaum never addressed Dr. Kendrick's immobilization theory. We conclude that that deficiency undercuts the persuasiveness of Dr. Rosenbaum's reports. Therefore, we rely on Dr. Kendrick's reports.

Shortly after claim closure, Dr. Kendrick offered treatment that had not been proposed before with a reasonable hope of improving claimant's low back condition. Because claimant's condition remained unchanged between claim closure and the time claimant saw Dr. Kendrick, in light of Dr. Kendrick's post-closure reports suggesting that claimant could possibly benefit from surgery, we conclude that claimant's condition was not medically stationary on the date of closure. See Scheuning v. J. R. Simplot & Company, supra, 84 Or App at 626; see also Flor Irajpanah, 45 Van Natta 566 (1993).

Because we have concluded that claimant's claim was prematurely closed, we do not address claimant's permanent disability.

Having concluded that claimant's claim was prematurely closed, we further conclude that claimant's counsel is entitled to an attorney fee payable from any increased compensation created by this order, not to exceed $3,800, and payable directly to claimant's counsel. ORS 656.386(2); OAR 438-15-055.

ORDER

The Referee's order dated June 21, 1993 is reversed. The September 12, 1990 Determination Order and the June 3, 1991 Order on Reconsideration are set aside as premature. The claim is remanded to the self-insured employer for further processing according to law. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

In the Matter of the Compensation of
JOSHUA L. DETTER, Claimant
WCB Case No. 93-02669
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee Menashe's order that upheld the insurer's denial of claimant's left groin injury claim. In his brief, claimant asks the Board to strike the testimony of two witnesses from the record. On review, the issues are motion to strike and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Finding that there were discrepancies and conflicts between claimant's statements to the insurer and his testimony at hearing, the Referee concluded that claimant was not a reliable witness. The Referee further found co-worker Jordan and co-worker Waverly to be credible witnesses. The Referee concluded, therefore, that claimant failed to establish by a preponderance of the evidence that he sustained a compensable injury.

On review, claimant contends that because the insurer did not timely disclose statements from supervisor Muller and co-worker Waverly, the Board should strike their testimony from the record. Claimant further contends that because every physician who has examined him indicates that claimant's left groin condition resulted from a lifting injury at work, claimant has established that the industrial injury of December 11, 1992 was a material contributing cause of his left groin strain.

The insurer interviewed claimant, Muller and Waverly prior to issuing its denial. The insurer did not interview Jordan. Claimant, Muller, Waverly and Jordan testified at hearing. The Referee disregarded Muller's testimony, relying instead on the testimony of Waverly and Jordan. Even if we were to disregard both Muller and Waverly's testimony (that is, consider only the testimony of claimant and Jordan), we would nonetheless find that claimant has failed to establish that his work activities are a material contributing cause of his left groin condition. Therefore, even if we granted claimant's motion to strike the testimony of Muller and Waverly, we would continue to conclude that the claim is not compensable.

We agree with the Referee's finding that Jordan testified in a believable manner and was a credible witness. We also agree with the Referee's finding that claimant was not forthcoming in his statement to the insurer and was not a reliable witness. Therefore, although claimant's treating physician and the examining physicians may attribute claimant's groin condition to his work activities, we do not find their opinions, which were are based on an inaccurate history, particularly persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Consequently, as clarified and modified herein, we adopt the Referee's opinion that claimant has failed to establish by a preponderance of the evidence that he sustained a compensable injury. ORS 656.266.

ORDER

The Referee's order dated June 15, 1993 is affirmed.

In the Matter of the Compensation of
JERRY R. TESTERMAN, Claimant
WCB Case No. 93-04408
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Barber's order, as reconsidered by Referee Schultz, that: (1) dismissed claimant's hearing request concerning the insurer's March 24, 1993 denial of claimant's claim for a right leg and lower back condition; (2) declined to grant an evidentiary hearing to determine whether claimant's hearing request should have been dismissed; and (3) declined to grant claimant's alternative motion that his hearing request be postponed. On review, the issue is the propriety of the dismissal order and postponement.

We adopt and affirm Referee Barber's order, as reconsidered by Referee Schultz, with the following supplementation.

Claimant's former attorney requested a hearing regarding the insurer's March 24, 1993 denial of claimant's claim. A hearing was set before Referee Barber on July 7, 1993. Claimant was present at the July 7, 1993 hearing and was represented by his former attorney, who stated that both he and claimant had been unable to get a response from Dr. Franks, whom they had reason to believe might indicate that claimant's claim was work related. (Tr. 1). Claimant's former attorney also stated that, as the record stood, he and claimant did not believe they could meet their burden of proof. On that basis, claimant's former attorney requested that claimant's hearing request be dismissed. (Tr. 1). Accordingly, Referee Barber issued an Order of Dismissal on July 20, 1993.

Subsequently, claimant sought the advice of another attorney. On July 27, 1993, claimant, through his new attorney of record, requested that the Order of Dismissal be withdrawn and that he be given an evidentiary hearing to determine whether or not the hearing request should have been dismissed. Referee Barber abated the Order of Dismissal to allow the parties an opportunity to address this issue. Before the matter could be resolved, Referee Barber's limited duration position as a Hearings Division Referee expired and Referee Schultz was assigned the matter. In his response to Referee Schultz, claimant for the first time moved that his hearing request be postponed, as an alternative request for relief. Referee Schultz declined to grant either claimant's request for an evidentiary hearing or his request for a postponement and reinstated the dismissal order.[1]

On review, claimant argues that he should be granted an evidentiary hearing to determine whether or not the dismissal was proper. Specifically, claimant seeks "the opportunity to establish, if he can, that he did not authorize his [former] attorney to dismiss the request for hearing, and that he did not understand the significance of the events as they were occurring at the hearing." (Claimant's Appellant's Brief, page 2-3). Claimant argues that the procedure established by the Board to handle the circumstances presented by his case was not followed by the Referee. In support of his argument, claimant cites Eul G. Moody, 45 Van Natta 835 (1993), and Kenneth W. Dortch, 44 Van Natta 2163 (1992).

We do not agree with the claimant's interpretation of the aforementioned holdings. In both Moody and Dortch the claimants were represented and hearings were set regarding their cases. Prior to the scheduled hearings, their former attorneys notified the respective referees that the claimants were withdrawing their hearing requests. As a result, the referees entered orders of dismissal. Subsequently,

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[1] Prior to Referee Schultz's decision, claimant requested another hearing regarding the insurer's March 24, 1993 denial. The insurer argues that we should: (1) take administrative notice of Referee Menashe's November 16, 1993 order which issued following claimant's second hearing; and (2) address Referee Menashe's advisory finding that claimant had not proved the compensability of his claim. Because we hold that claimant is not entitled to further proceedings in the present case, either in the form of an evidentiary hearing or a postponement of his first hearing, we do not address the insurer's arguments.

the claimants, then pro se, requested review of the referees' orders of dismissal. The Board affirmed the referees' orders of dismissal, finding that the records established that the claimants, through their attorneys, had withdrawn their hearing requests and that there was no evidence to contradict that finding. Eul G. Moody, supra; Kenneth W. Dortch, supra; see also Verita A. Ware, 44 Van Natta 2163 (1992).

Claimant appears to rely on the fact that the Board stated that there was "no evidence to contradict" its finding that the claimants, through their attorneys, withdrew their hearings requests as providing a basis for an evidentiary hearing regarding claimant's state of mind when his former attorney withdrew his hearing request. Claimant's interpretation of Moody, supra, and Dortch, supra, is overbroad. No procedure for an evidentiary hearing regarding a claimant's state of mind when his or her attorney withdraws his or her hearing request was established or even suggested by the holdings in Moody, supra, and Dortch, supra. Rather, the usual procedure of determining whether the record supported the findings was followed.

As in Moody, supra, Dortch, supra, and Ware, supra, the record here establishes that claimant, through his former attorney, withdrew his hearing request. (Tr. 1). Claimant does not dispute the fact that his former attorney represented him at hearing and that his former attorney withdrew the hearing request. In fact, claimant's case is less compelling than Moody, supra, Dortch, supra, and Ware, supra. There, no hearings were held because the requests for hearing were withdrawn before the scheduled hearing dates. Here, a hearing was held and claimant was present when his former attorney withdrew the hearing request. In any event, in all of these cases, including the present case, the claimants were represented and, through their attorneys, withdrew their hearings requests. Thus, we find that the dismissal order was appropriate.

In addition, claimant argues that the Referee should have granted his post-hearing request for postponement of the hearing. Claimant cites Betty L. Harper, 45 Van Natta 724 (1993), in support of his argument. There, the claimant's attorney withdrew the request for hearing prior to the scheduled hearing. Therefore, no hearing took place and the Referee entered a dismissal order. Subsequently, the Board received claimant's response to the Referee's order. The Board treated claimant's response as a request for postponement. The Board found that it had previously held that a referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867, and Mark R. Luthy, 41 Van Natta 2132 (1989). Because the Referee did not have an opportunity to rule on the motion, the Board remanded the matter to the Referee for consideration of the claimant's motion for postponement. Betty L. Harper, supra.

We find Harper inapposite. Unlike Harper, here, there was a hearing and claimant's "post-dismissal order" request for postponement was considered by the Referee. Referee Schultz found that claimant failed to demonstrate any "extraordinary circumstances" that would justify a postponement. OAR 438-06-081. We agree.

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 dismissal order or the denial of claimant's motion for postponement. Henry B. Scott, 45 Van Natta 2392 (1993); Mike D. Sullivan, 45 Van Natta 900 (1993).

As we stated in Sullivan, supra, at 45 Van Natta 991, "[i]f claimant disagrees with his prior counsel's decision to withdraw his hearing request (which was made in claimant's presence and with claimant's implicit approval), he must present this matter to his former attorney, rather than this forum."

ORDER

Referee Barber's order dated July 20, 1993, as reconsidered by Referee Schultz on September 23, 1993, is affirmed.

In the Matter of the Compensation of
JEAN E. CASH, Claimant
WCB Case No. 93-01782
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Livesley's order that set aside its denial of claimant's bilateral knee, low back and left dominant toe injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, but not the Findings of Ultimate Fact, with the following modification and supplementation.

In lieu of the fifth paragraph on page 2 of the Opinion and Order, we find:

Employee breaks are determined by the employer's store manager. Employees who work less than eight hours on a given day are allowed a 15-minute lunch period that day. The employer had previously provided 20 minutes for this function. Because of the reduction of the time allowed for lunch, claimant did not eat at mall restaurants, but rather consumed her lunch on the employer's premises.

In lieu of the seventh paragraph on page 2 of the Opinion and Order, we find:

On November 3, 1992, the day of claimant's accident, the district manager was scheduled to visit the store where claimant was employed. Denise Jackson (Jackson), the store manager, and Kathleen Huff, an assistant manager, and one other manager planned to meet with the district manager. To ensure that there would be sufficient sales staff to assist customers while the store managers met with the district manager, Jackson asked that all breaks be completed before the end of claimant's shift. Because of the anticipated arrival of the district manager, claimant was expected to be on call during her lunch break.

Sometime before her scheduled break, claimant discovered that she had inadvertently left her lunch in her car. She asked Jackson for permission to retrieve her lunch. Jackson gave claimant permission to do so, because she wanted claimant to be available to assist customers during her lunch break, if necessary.

Claimant left the front entrance of the employer's premises on her way to her car. As she crossed the common area in front of the premises, she slipped and fell, injuring her knees, low back and left dominant toe. Claimant was on duty when she fell.

CONCLUSIONS OF LAW AND OPINION

Credibility

We adopt the Referee's conclusions regarding credibility.

Course and Scope of Employment

We adopt the Referee's conclusions regarding whether claimant's injuries arose out of and in the course of her employment, with the following modification and supplementation.

In lieu of the Referee's finding that claimant was told to retrieve her lunch from her car (Opinion and Order at 5, 6), we find that the employer acquiesced in her request to obtain her lunch, so that claimant could be on call during her lunch period that day.

In addition to the Referee's analysis regarding whether the employer contemplated claimant's trip to her car, (Opinion and Order at 5), we conclude as follows:

The evidence establishes that, when the district manager visited the store, the employer required sales associates, including claimant, to be available to assist customers during their lunch breaks. Under the circumstances, we conclude that the employer must have contemplated that, on these days, employees might request to leave the premises for a short period of time to obtain a meal. Because the district manager was scheduled to visit the store on the day of the accident, and because the object of claimant's trip to her car was to retrieve her lunch so that she could eat her meal on the employer's premises and thereby be available to assist customers during her lunch break, we conclude that the trip was an activity contemplated by the employer.

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

ORDER

The Referee's order dated October 18, 1993 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ROY J. JOHNSON, Claimant
WCB Case No. 93-01380
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband & Hall.

Claimant requests review of Referee Michael V. Johnson's order which upheld the insurer's denial of claimant's low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant works as a roofer for the employer. His job involves two primary duties: (1) "tearing off" old roofing and preparing the roof for new roofing; and (2) "roofing." His compensation is determined by the job duty.

When "tearing off," roofers assemble at the employer's shop and ride to the job site in company vehicles. When "tearing off," claimant is paid on an hourly basis and is paid for travel time to and from the job site and the shop.

When "roofing," claimant is paid on a piece-work basis. The employer has no specific requirements regarding how the roofers get to the job site, but he prefers that they go directly to the job site rather than stopping at the shop. The roofers can choose whether to travel directly to the job site or to first come to the employer's shop and then to the job site. When roofing, claimant receives no compensation for travel time, except when attending a mandatory safety meeting at the shop or when the job site is beyond a certain distance from the employer's shop.

Since claimant has no driver's license, he primarily relies on his wife and coworkers for transportation to and from work. Claimant's wife usually took him to the employer's shop, to the job site, or to a coworker's house. At the time of the accident, claimant lived in Dundee. The employer's shop is located in Newberg.

On the day of injury, claimant's wife drove him to a coworker's house and then the coworker drove claimant directly to the job site in the Portland area. Claimant was "roofing" that day. At the

end of the work day, claimant asked one of the foremen, Augustine Alvarez who had just arrived from another job site, for a ride to the shop, because it would get him closer to home. Otherwise, claimant did not have a ride home. Neither the employer nor Alvarez had prior knowledge that claimant intended to ask Alvarez for a ride to the employer's shop.

Within approximately a mile from the shop, the company pickup Mr. Alvarez was driving (and in which claimant was a passenger) was rear-ended. Claimant injured his back in the accident. When they arrived at the shop, Mr. Alvarez and claimant unloaded the material in the pickup. Claimant then received a ride home from another coworker.

As a foreman, Mr. Alvarez was required to return materials to the shop and unload the company pickup upon arriving at the shop. Mr. Alvarez was paid for this work. Claimant was not paid for helping Mr. Alvarez unload the pick-up. Nevertheless, claimant was expected to help Alvarez unload the truck, pursuant to the employer's "custom and practice" which encouraged such "pitching in" as a means to instill teamwork and to promote camaraderie among the workers.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the seven factors of the work relationship test enunciated in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), and found that claimant's injury did not have a sufficient relationship to work and, therefore, was not compensable. In the alternative, the Referee found that the "dual purpose" exception to the "coming and going" rule was inapplicable because the purpose of claimant's trip to the employer's shop was personal. We reverse and find that claimant's injury arose out of and in the course of employment.

In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Court explained that there are two elements in determining whether an injury is compensable: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Each element is part of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Id. at 366; Rogers v. SAIF, 289 Or 633 (1980).

In adopting a unitary "work-connection" approach, the Supreme Court quoted with approval from Allen v. SAIF, 29 Or App 631, 633-634 (1977), the following explanation for the policy behind this approach:

> "The statutory phrase 'arising out of and in the course of employment' must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation Act. *** Various concepts have arisen from attempts to rationalize that purpose, e.g., the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. [citation omitted] Rather, in each case, every pertinent factor must be considered as a part of the whole. ****" Rogers v. SAIF, supra.

In determining whether claimant's injury arose "in the course of" employment, the "going and coming" rule applies, under which injuries sustained while going to or coming from work are generally not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where an employer agrees, either expressly or impliedly, that the employment relationship shall continue during the period of "going to and coming from" the actual job site, it is generally held that an injury sustained while "going or coming" is one that "arises out of and in the course of the employment." Gwinn v. Liberty Northwest Ins. Co., 105 Or App 171, 176 (1991) (J. DeMuniz dissenting; citing I-L Logging Co. v. Mfgrs. & Whlse. Ind. Exc., 202 Or 277 (1954)).

Claimant's travel to various job sites is a necessary incident of employment. Although not required, claimant usually returned to the employer's shop on his way home. Claimant testified that, whenever he was in the shop, he helped unload material whether it was his or not. The employer had, in fact, encouraged the roofers to help unload materials. Although claimant was "technically" (for

purposes of the employer's business records) off-duty and to that extent, "voluntarily" helped Alvarez unload the truck on the day of the accident, such helping out was expected of claimant and had become customary. After receiving a ride from Alvarez, claimant expected to, and did in fact, help Alvarez to unload the pickup. Thus, by encouraging this policy of "teamwork" in unloading materials, the employer had impliedly agreed that the relationship between himself and claimant would continue while claimant was travelling to and from a job site.[1]

In essence, claimant was travelling between two portions of the employer's premises--the Cedar Hills job site where he did roofing and the employer's shop where he unloaded materials--when he was injured. Thus, the travel to the employer's shop was part of the service performed for the employer. Claimant has satisfied the "in the course of employment" element.

Claimant was still within the course of employment while riding to the employer's shop, he was riding in a truck owned by the employer, and it was contemplated that claimant would help unload the truck upon arrival at the employer's shop. Under these circumstances, we are not persuaded that the otherwise personal nature of the trip--to get closer to home--was sufficient to sever the work connection. Thus, the risk that claimant would be injured while travelling to the employer's shop was a risk of his employment. Accordingly, we conclude that claimant has established that his injury arose out of and in the course of employment.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $2,700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 14, 1993 is reversed. The insurer's denial is set aside and the claim remanded to the insurer for processing according to law. Claimant's attorney is awarded $2,700 for services at hearing and on Board review, to be paid by the insurer.

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[1] Under the Mellis seven factor test, this teamwork (1) was a benefit to the employer and (2) was contemplated by the employer and employee. See e.g., Ester E. Edwards, 45 Van Natta 1065 (1992) (injury during volleyball game sponsored and organized by employer to improve communication between workers); cf. SAIF v. Reel, 303 Or at 218 (the claimant, during off-duty hours, was free to do as he pleased, without respect to the employer's job site).

Board Member Hall, specially concurring.

Although I agree with the lead opinion's holding that claimant's injury arose out of and in the course of employment, I would hold, as an additional ground, that the "in the course of employment" element is satisfied under the "employer conveyance" exception to the "going and coming" rule.

Larson states the "employer's conveyance" rule as follows:

> "When the journey to or from work is made in the employer's conveyance, the journey is in the course of employment, the reason being that the risks of the employment continue throughout the journey." 1 Larson, Workmen's Compensation Law 4-209, §17.00 (1985).

> "If the trip to and from work is made in a truck, bus, car, or other vehicle under the control of the employer, an injury during that trip is incurred in the course of employment." 1 Larson, supra, 4-209, § 17.11 (1985); Giltner v. Commodore Con. Carriers, 14 Or App 340 (1972).

The reason for the rule is that the risk of employment continues throughout the journey (i.e., there is an extension of the employer-controlled risk of employment). 1 Larson, supra, 4-218 § 17.11.

The claimant in Giltner, supra, was a truck driver who leased his truck to the employer. The claimant lived in Portland and picked up mobile homes in Roseburg (where employer's manufacturing plant was located) for delivery. The claimant was injured while driving his truck to Roseburg. The court relied on Larson's "employer conveyance" rule to find that that injury occurred in the course and scope of employment. It reasoned that the claimant was required to use his own truck, and pursuant to the lease, the employer had exclusive control of the truck. Giltner, 14 Or App at 346-347.

Here, claimant was injured while a passenger in a truck owned by the employer and under the control of the employer's foreman. It was not improper for claimant to ride with Alvarez (Tr. 71), and Alvarez agreed to give claimant a ride. Providing this ride expanded the range of risks assumed by the employer and under the employer's control, such that claimant remained within the course of employment.

Accordingly, I would hold that claimant's injury is compensable under the "employer conveyance" rule, because claimant was traveling in the employer's pickup, which was under the employer's control.

June 8, 1994 Cite as 46 Van Natta 1120 (1994)

In the Matter of the Compensation of
LINDA D. LUNOW, Claimant
WCB Case No. 93-03164
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Hall, Westerband, and Haynes.

Claimant requests review of Referee Peterson's order which upheld the SAIF Corporation's denial of her low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right knee on June 29, 1989. The claim was closed by Determination Order of November 26, 1991, with an award of 18 percent scheduled permanent disability for loss of use or function of the right leg (knee).

Claimant returned to work, but favored the right knee because of pain. In the spring of 1992, she experienced a gradual onset of low back pain without specific injury or incident. Dr. Gripekoven, claimant's attending physician, opined that an altered gait was responsible for her back complaints. Degenerative disc disease and spina bifida oculta were diagnosed. On December 23, 1992, SAIF denied claimant's low back treatment, spina bifida oculta and degenerative disc disease at L3/4 on the grounds that they were unrelated to the June 29, 1989 right knee injury.

At hearing, claimant conceded that the spina bifida oculta was not compensable. The Referee held that claimant's low back condition was not compensable, finding insufficient medical evidence to establish that claimant's right knee injury was the major contributing cause of her low back condition.

Claimant contends that, based on Dr. Gripekoven's medical opinion, she has proved that medical treatment for her low back condition is compensable. The Referee had discounted Dr. Gripekoven's opinion because of perceived inconsistencies in his opinion. Because the examining physicians, Drs. Brown, Donohoo and Mandiberg, had concluded that claimant's June 29, 1989 injury was not the major contributing cause of claimant's low back condition, the Referee determined that claimant had failed to satisfy her burden of proof. We disagree.

Before addressing the persuasiveness of Dr. Gripekoven's opinion, we note a threshhold issue regarding the applicable statutory provision governing the low back claim. The Referee and the parties analyze this as a consequential condition claim under ORS 656.005(7)(a)(A). This analytical framework is reasonable since neither SAIF nor claimant contend that the low back condition arose as a direct result of claimant's June 29, 1989 accident. That is, the parties frame the issue as whether the low back condition is compensable as a secondary consequence of claimant's right knee injury (i.e. her altered gait). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

On the other hand, claimant has a preexisting degenerative disc disease that arguably combined with sequela of the compensable knee injury (altered gait) to cause a need for medical treatment for the low back. Assuming that ORS 656.005(7)(a)(B) applies, the "resultant condition" would be compensable if the compensable right knee injury was the major contributing cause of the "disability or need for treatment" for claimant's low back. In contrast, ORS 656.005(7)(a)(A) requires that the compensable injury be the major contributing cause of the "consequential condition." We need not determine which specific provision is applicable in this case, for we find that claimant's low back condition and need for medical treatment are compensable under either statute.

Based on claimant's preexisting low back condition and its disputed relationship to claimant's compensable right knee injury, we find that this claim involves a complex question of medical causation. Consequently, expert medical evidence is required for its resolution. See Uris v. Compensation Department, 247 Or 420 (1967). Absent persuasive reasons to do otherwise, we generally give greater weight to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810, 814 (1983). Unlike the Referee, we do not find persuasive reasons to discount Dr. Gripekoven's opinion.

Although Dr. Gripekoven concurred with the medical reports of the examining physicians, he also indicated that claimant's need for medical treatment for her low back was directly related to an altered gait resulting from claimant's right knee injury. (Exs. 32, 34, 40). At his deposition, Dr. Gripekoven explained in detail his medical opinion. (Ex. 42).

Dr. Gripekoven testified that, while the degenerative disc disease remains the main source of her back problems, claimant's altered gait resulting from her knee injury and her ongoing work activities rendered a previously asymptomatic degenerative disc disease symptomatic. Therefore, the compensable knee injury was the major contributing cause of claimant's need for treatment for her low back symptoms. (Ex. 42-5). Dr. Gripekoven explained that, once treatment for the acute flareup of back pain was completed, then the degenerative condition would become the major factor in claimant's low back condition. (Ex. 42-6).

In light of this explanation, we do not find Dr. Gripekoven's observations to be inconsistent. Instead, we consider his opinion to be persuasive, consistent and well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986). We accordingly find no persuasive reason not to defer to Dr. Gripekoven's opinion. Weiland v. SAIF, supra. We, therefore, conclude that claimant has satisfied her burden of proving that medical treatment for the symptomatic exacerbation of her previously asymptomatic degenerative disc disease is compensable. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

Given the "combination" of claimant's preexisting degenerative disc disease and her compensable injury, the "resultant condition" is probably compensable under ORS 656.005(7)(a)(B). However, even if that statute does not apply, claimant's low back condition would still be compensable as a "consequential condition" under ORS 656.005(7)(a)(A). Based on Dr. Gripekoven's medical reports, we find that the "consequential condition" is the symptomatic flareup of the previously asymptomatic preexisting degenerative disc disease. Since we find that claimant's compensable knee injury is the major contributing cause of claimant's need for medical treatment for the symptomatic exacerbation of her preexisting asymptomatic degenerative disc disease, it follows that the compensable injury would also be the major causal factor in the "consequential condition," i.e., the symptomatic exacerbation of the degenerative condition. Thus, we conclude that claimant's symptomatic flare-up and related medical treatment are compensable under either subsection (7)(a)(B) or (7)(a)(A) of ORS 656.005.

Claimant's counsel is entitled to attorney fees for services at hearing and on review concerning the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-

010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated August 30, 1993 is reversed. The SAIF Corporation's denial is set aside to the extent that it denies treatment for a symptomatic exacerbation of claimant's preexisting low back degenerative disc disease. The claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by SAIF.

Board Member Haynes dissenting.

The majority finds Dr. Gripekoven's medical opinion consistent and concludes that claimant has sustained her burden of proving that medical treatment for a symptomatic exacerbation of her preexisting degenerative disc disease is compensable. Because I agree with the Referee that Dr. Gripekoven's opinions are inconsistent, I would affirm the Referee's order.

As the majority acknowledges, Dr. Gripekoven concurred with two examining physician reports which concluded that the major contributing cause of claimant's back condition was the degenerative disc disease at L3-4. (Exs. 33, 41). Dr. Gripekoven authored other reports that implicated claimant's knee injury as the cause of claimant's back problems on an altered gait theory. (Exs. 32, 34, 40). The majority finds that Dr. Gripekoven's testimony adequately explains the obvious inconsistencies in his medical opinion. I disagree.

While Dr. Gripekoven appeared to conclude that claimant's knee injury was the major contributing cause of her need for treatment, at least initially, he also testified that claimant's underlying back condition "remains the main cause or source" of her back problems. (Ex. 42-5). In light of this testimony, I believe the inconsistencies in Dr. Gripekoven's opinion remain even after the deposition. Because of this, I would find that claimant has failed to sustain her burden of proof and affirm the Referee.

For all these reasons, I respectfully dissent.

In the Matter of the Compensation of
JEFF C. TUNEM, Claimant
Own Motion Nos. 88-0721M, 93-0766M, & 93-0773M
OWN MOTION ORDER ON RECONSIDERATION AND ORDER REVIEWING CARRIER CLOSURE
Royce, Swanson, et al., Claimant Attorneys

Claimant requested reconsideration of our November 18, 1993 Own Motion Order, as amended on December 9, 1993, in which we authorized the self-insured employer's voluntary reopening of claimant's June 27, 1982 low back injury claim. (Own Motion No. 93-0766M). Claimant also requested reconsideration of our November 30, 1993 Own Motion Order, as amended on December 9, 1993, in which we denied reopening of claimant's claim for own motion relief on the ground that he did not require surgery or other treatment requiring hospitalization. (Own Motion No. 93-0773M).

In addition, claimant requests review of the employer's two Notices of Closure, both dated November 12, 1993. (Own Motion Nos. 88-0721M, 93-0766M). Because the claims involved in claimant's requests for reconsideration are interrelated with the claims involved in claimant's requests for review of carrier closure, we consolidate these requests and address both matters in this order.

FINDINGS OF FACT

On June 27, 1982, claimant injured his low back and the employer accepted the injury as disabling. That claim was first closed by Determination Order on September 12, 1983. Claimant's aggravation rights on that claim expired on September 12, 1988.

On July 15, 1985, claimant sustained a separate injury to his low back. The employer accepted that injury as disabling and the claim was first closed by Determination Order on December 15, 1985. Claimant's aggravation rights on that claim expired on December 15, 1990.

On November 30, 1987, claimant sustained new injuries to his low back and right knee. The employer accepted those injuries as disabling and the claim was first closed by Determination Order on August 3, 1988. Claimant had 180 days within which to appeal from that Determination Order.

On October 28, 1988, Dr. Kaesche, claimant's treating orthopedic surgeon, requested authorization to perform a laminotomy-diskectomy, L4-5 on the right with a possible exploration of L5, S1. In an October 28, 1988 chart note, Dr. Kaesche stated that claimant has had evidence of bulging and abnormalities at L4-5 since 1982.

On December 8, 1988, the Board, in its own motion authority, reopened claimant's June 27, 1982 low back injury claim. (Own Motion No. 88-0721M). The Board ordered that, when appropriate, the employer was to close the claim pursuant to OAR 438-12-055. Claimant did not request reconsideration of that order or challenge it in any way.

On November 9, 1988, Dr. Kaesche performed surgery at L4-5. By letter dated October 6, 1989, Dr. Kaesche opined that claimant was medically stationary as of May 15, 1989, and remained so in June 1989, when Dr. Kaesche last saw claimant. Dr. Kaesche's chart notes from May and June 1989 support this opinion.

On November 12, 1993, the employer closed the reopened June 27, 1982 low back injury claim by Notice of Closure pursuant to OAR 438-12-055. In that Notice of Closure, the employer: (1) awarded claimant temporary total disability compensation from October 17, 1988 through January 30, 1989; (2) awarded temporary partial disability from January 31, 1989 through June 13, 1989; and (3) declared claimant medically stationary as of May 15, 1989. Claimant requested review of that Notice of Closure, contending that the claim should have been closed pursuant to ORS 656.268. (Own Motion No. 88-0721M).

In the meantime, the employer had voluntarily reopened claimant's June 27, 1982 low back injury claim for a January 24, 1990 surgery involving L5-S1, which was performed by Dr. Brett, claimant's treating neurosurgeon. On November 18, 1993, the Board authorized the employer's voluntary reopening of the June 27, 1982 injury claim. (Own Motion No. 93-0766M). In its November 18, 1993 order, the Board identified the date of injury of the voluntarily reopened claim as June 27, 1988. On December 9, 1993, the Board issued an amended order which corrected the date of injury to read June 27, 1982. (Own Motion No. 93-0766M). Claimant requested reconsideration of the Board's order.

In a June 13, 1990 chart note, Dr. Brett opined that claimant was medically stationary. Following his review of additional testing, Dr. Brett opined that claimant remained medically stationary as of March 3, 1993, and stated that there was no indication for further operative intervention or curative treatment. (Letter dated March 3, 1993 from Dr. Brett to the employer's processing agent).

Claimant participated in a six week rehabilitation program at Back-in-Action, which ended about July 15, 1993. At the end of that program, Dr. Slack, the medical director, opined that claimant was medically stationary. (July 15, 1993 Final Medical Evaluation from Dr. Slack).

By a second Notice of Closure dated November 12, 1993, the employer closed the voluntarily reopened June 27, 1982 claim. In that Notice of Closure, the employer: (1) awarded claimant temporary total disability from December 8, 1989 through April 17, 1990; (2) awarded temporary partial disability from April 18, 1990 through May 24, 1990; and (3) declared claimant medically stationary as of June 13, 1990. Claimant requested review of that Notice of Closure, contending that the voluntarily reopened claim should also have been closed pursuant to ORS 656.268. (Own Motion No. 93-0766M).

On November 30, 1993, the Board issued an order under its own motion authority denying reopening of the June 27, 1982 back injury claim because the record failed to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. (Own Motion No. 93-0773M). Claimant requested reconsideration of that order.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

As a preliminary matter, we note that claimant requests that the Board consolidate the current own motion matters with a hearing scheduled before the Hearings Division on August 24, 1994. (WCB Case Nos. 93-10835, 94-02260, 94-02261). However, we do not find the record inadequately developed regarding the own motion matters before us. This is especially true since, as discussed below, claimant primarily relies on a legal argument to support his assertions regarding the own motion matters. Accordingly, the Board declines to grant claimant's request for consolidation.

Reconsideration of Own Motion Order dated November 18, 1993, as amended on December 9, 1993, (Own Motion No. 93-0766M) and Own Motion Order dated November 30, 1993, as amended on December 9, 1993 (Own Motion No. 93-0773M)

In order to consider claimant's motion for reconsideration, we withdrew our November 18, 1993 and November 30, 1993 orders, as amended, and granted the employer an opportunity to respond to claimant's motion. The employer's response has been received and we proceed with our reconsideration.

On reconsideration, claimant asserts that the claim reopened by the Board's December 8, 1988 order (Own Motion Claim No. 88-00721M) should have been closed pursuant to ORS 656.268 rather than OAR 438-12-055. Claimant also argues that, because the claim reopened by the Board's December 8, 1988 order should have been closed pursuant to ORS 656.268, it follows that: (1) the later claim that was voluntarily reopened by the employer should also have been closed pursuant to ORS 656.268 (Own Motion No. 93-0766M); and (2) since both of these earlier reopened claims should have been closed pursuant to ORS 656.268, his claim continues to have aggravation rights and the Board did not have own motion jurisdiction to deny reopening his claim in Own Motion No. 93-0773M. Claimant bases his assertion on two separate arguments.

First, claimant argues that the claim reopened by the December 8, 1988 Own Motion Order should have been reopened as an aggravation of a later November 30, 1987 accepted low back injury claim rather than as a worsening of the 1982 low back injury.[1] Claimant is essentially arguing that his claim was not in the Board's own motion jurisdiction at the time it was ordered reopened as an own motion claim because his condition was caused by a later compensable injury on which the aggravation rights had not yet expired.

We acknowledge that the issue of subject matter jurisdiction may be raised at any time in the course of litigation. Schlect v. SAIF, 60 Or App 449 (1982); Dena M. Smith, 38 Van Natta 147 (1986), aff'd Smith v. Ridgepine Inc., 88 Or App 147 (1987). In addition, the filing requirements of ORS 656.273 are jurisdictional. Timothy D. Beard, 43 Van Natta 432 (1991); Denise A. Robinson, 42 Van Natta 2514 (1990). A claim for additional compensation made within the time limits of ORS 656.273 is not within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

However, claimant submits no evidence to support his argument that his condition in 1988 was the result of the compensable 1987 back injury rather than the 1982 back injury. Instead, he simply states that the November 30, 1987 injury claim should have been reopened "because it was the more recent injury to the same part of the back."

Furthermore, the evidentiary record does not support claimant's argument. In an October 28, 1988 chart note, Dr. Kaesche, treating orthopedist, stated that claimant had a herniated disc at L4-5 and that review of claimant's old records showed evidence back to 1982 of bulging and abnormalities of that

[1] The aggravation rights on the 1982 injury claim had expired at the time of the December 8, 1988 Own Motion Order. Thus, that claim was within the Board's own motion jurisdiction. ORS 656.273(4); 656.278; Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

disc level. On November 9, 1988, Dr. Kaesche performed surgery at L4-5. It was this surgery for which the claim was reopened by the December 8, 1988 Own Motion Order. Thus, the only evidence in the record concerning the need for the 1988 surgery relates it to lumbar problems beginning in 1982. There is no evidence in the record relating the need for the surgery to the 1987 injury.

Second, claimant argues that the 1982 injury claim that was reopened by the December 8, 1988 Own Motion Order should have been closed pursuant to ORS 656.268 because it was reopened within the time period for appealing an August 3, 1988 Determination Order that closed the November 30, 1987 injury claim. In support of his argument, claimant cites OAR 438-12-055(2) and Tony E. Alfano, 45 Van Natta 205 (1993), which in turn relied on Carter v. SAIF, 52 Or App 1027 (1981), and Coombs v. SAIF, 39 Or App 293 (1979). We disagree that the reopening of a 1982 injury during the appeal period for a Determination Order relating to a separate 1987 injury entitles the reopened 1982 claim to be closed pursuant to ORS 656.268.

ORS 656.278(2) provides that "[a]n order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS 656.273 is not an order or award, as the case may be, made by the board on its own motion." ORS 656.278(2) was not changed by the 1990 amendments to the Workers Compensation Law. Therefore, this statute retains the same language it had when it was applied by the Court of Appeals in Carter v. SAIF, supra, and Coombs v. SAIF, supra.

In construing ORS 656.278, the court concluded:

> "[T]he legislature did not intend that a claimant's appeal rights granted by ORS 656.268(5) [now ORS 656.268(6)] should prematurely terminate when his aggravation rights expire. When a claim is opened during the time claimant still has appeal rights, closure of that claim carries with it the right of appeal whenever issued. This interpretation preserves a statutory right of appeal and avoids a harsh result." Coombs v. SAIF, supra, 39 Or App at 300, as cited in Carter v. SAIF, supra, 52 Or App at 1032.

In arguing to extend this reasoning to his case, claimant overlooks one relevant fact. Whereas both Coombs and Carter involved a single injury, as did Tony E. Alfano, supra, claimant has sustained three separate compensable injuries. As quoted above, the court interpreted the legislative intent as avoiding prematurely terminating a claimant's appeal rights when his aggravation rights expired.

Here, claimant was at no risk of having his appeal rights prematurely terminated regarding the August 3, 1988 Determination Order because that order related to a separate November 30, 1987 injury claim, and the aggravation rights on that 1987 injury claim would not expire within the appeal period for the 1988 Determination Order. Because his 1982 injury claim, which was in own motion status, was reopened during the appeal period of a Determination Order that involved a separate injury claim, claimant is not entitled to claim closure pursuant to ORS 656.268. In other words, ORS 656.278(2) does not apply to the circumstances of claimant's reopened claim. Coombs v. SAIF, supra; Carter v. SAIF, supra. Therefore, based on the above, we conclude that the December 8, 1988 Own Motion Order that reopened claimant's 1982 injury claim was correctly ordered closed pursuant to OAR 438-12-055.

Claimant also argued that: (1) because the December 8, 1988 reopening of his claim should have been closed pursuant to ORS 656.268, the employer's subsequent voluntary reopening of his 1982 claim (Own Motion No. 93-0766M) should also have been closed pursuant to ORS 656.268; and (2) because those earlier reopenings should have been closed pursuant to ORS 656.268, he retained aggravation rights and, therefore, the Board did not have own motion jurisdiction over his claim and could not deny its reopening on the ground that he did not require surgery or other treatment requiring hospitalization. (Own Motion No. 93-0773M). These arguments rely on claimant's assertion that the December 8, 1988 reopening of his claim should have been closed pursuant to ORS 656.268. Because we reject that assertion, we necessarily reject these additional arguments that are based on that assertion.

Accordingly, our November 18, 1993 Own Motion Order, as amended on December 9, 1993, and our November 30, 1993 Own Motion Order, as amended on December 9, 1993, are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 18, 1993 Own

Motion Order, as amended on December 9, 1993, and our November 30, 1993 Own Motion Order, as amended on December 9, 1993, effective this date. The parties' rights of appeal shall run from the date of this order.

Review of Carrier Closures (Own Motion Nos. 88-0721M and 93-0766M)

Claimant requests review of the employer's two Notices of Closure, both dated November 12, 1993. The first November 12, 1993 Notice of Closure closed claimant's claim with regard to the December 8, 1988 Own Motion Order that had reopened claimant's claim. (Own Motion No. 88-0721M). That Notice of Closure: (1) awarded claimant temporary total disability compensation from October 17, 1988 through January 30, 1989; (2) awarded temporary partial disability from January 31, 1989 through June 13, 1989; and (3) declared claimant medically stationary as of May 15, 1989.

The second November 12, 1993 Notice of Closure closed claimant's claim with regard to the voluntary reopening authorized by our November 18, 1993 Own Motion Order, as amended on December 9, 1993. (Own Motion No. 93-0766M). That Notice of Closure: (1) awarded claimant temporary total disability from December 8, 1989 through April 17, 1990; (2) awarded temporary partial disability from April 18, 1990 through May 24, 1990; and (3) declared claimant medically stationary as of June 13, 1990.

Claimant argues that both claims should have been closed pursuant to ORS 656.268, rather than OAR 438-12-055. However, as discussed above, we reject claimant's argument and conclude that both claims were properly closed pursuant to OAR 438-12-055.

Claimant does not argue that he was not medically stationary at claim closure. Instead, his sole argument is that his claim should have been closed pursuant to ORS 656.268. The medical evidence in the record indicates that claimant was medically stationary at claim closure. Claimant presents no evidence to the contrary.

A claim may be closed if claimant's compensable condition is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981).

Regarding the claim reopened by the December 8, 1988 Own Motion Order (Own Motion No. 88-0721M), claimant underwent lumbar surgery in late 1988. By letter dated October 6, 1989, Dr. Kaesche, claimant's treating orthopedic surgeon, opined that claimant was medically stationary as of May 15, 1989, and remained so in June 1989, when Dr. Kaesche last saw claimant. Dr. Kaesche's chart notes from May and June 1989 support this opinion. The record contains no other opinion regarding claimant's medically stationary status following the 1988 lumbar surgery.

Regarding the claim that the employer subsequently voluntarily "reopened" as a result of claimant's January 24, 1990 lumbar surgery, Dr. Brett, claimant's treating neurosurgeon, opined that claimant was medically stationary on June 13, 1990. (June 13, 1990 chart note from Dr. Brett). Dr. Brett performed claimant's January 24, 1990 lumbar surgery. In addition, following his review of additional testing, Dr. Brett opined that claimant remained medically stationary as of March 3, 1993 and stated that there was no indication for further operative intervention or curative treatment. (Letter dated March 3, 1993 from Dr. Brett to the employer's processing agent).

Following Dr. Brett's March 3, 1993 opinion, claimant participated in a six week rehabilitation program at Back-in-Action. On July 15, 1993, at the end of that program, Dr. Slack, the medical director, opined that claimant was medically stationary in that further rehabilitation would not make a significant difference in his condition. (July 15, 1993 Final Medical Evaluation from Dr. Slack).

As noted above, the employer, through its processing agent, closed both reopened claims by separate Notices of Closure on November 12, 1993. The medical evidence from claimant's treating

surgeons indicates that claimant became medically stationary after each surgery. Claimant presents no evidence that he was not medically stationary at claim closure.

Accordingly, both of the employer's Notices of Closure dated November 12, 1993 are affirmed in their entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN D. WELLS, Claimant
WCB Case No. 92-09622
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Davis' order that: (1) authorized the self-insured employer to offset previously overpaid permanent disability against claimant's award for permanent disability; (2) declined to assess penalties for allegedly unreasonable claims processing; and (3) affirmed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg (knee). On review, the issues are offset, penalties and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The employer's first Notice of Closure awarded claimant $2,287.50, based on 7.5 degrees at $305 per degree. The employer issued an amended Notice of Closure correcting the value of the award to $1,087.50, based on 7.5 degrees at $145 per degree, and also changing the date claimant's aggravation rights began to run. The employer later issued a third Notice of Closure changing the aggravation rights back to the date of the original Notice of Closure. Claimant requested reconsideration under ORS 656.268(4)(e).

In October 1991, the Appellate Unit set aside the closure. The employer issued a fourth Notice of Closure on February 11, 1992 that increased the scheduled award to $2,827.50, based on 13 percent (19.5 degrees), and also notified claimant that "any compensation paid as permanent disability as a result of the [prior] notice of closure will be deducted from this award." The employer sent claimant a check for the difference between the permanent disability award already paid and the current award. The Referee concluded that the offset was authorized under ORS 656.268(13) because the employer had prematurely paid the permanent partial disability award.

Claimant asserts that the employer was "entitled to withhold previously paid permanent partial disability benefit equal to 5%, or $1,087.50." (Claimant's brief at 4-5). She contends, however, that the employer was not authorized to withhold an additional $1,200 because that amount was not "pre-paid permanent partial disability." (Id. at 5). We disagree.

ORS 656.268(13) provides:

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

See also OAR 436-30-020(12)(a); OAR 436-60-170.

Claimant creates a distinction without a difference and reads the statute too narrowly. Although 656.268(13) includes "disallowance of permanent disability payments prematurely made," it refers more broadly to "adjustments in compensation paid or payable prior to the determination or notice of closure." Claimant does not contend that she did not receive the disputed payment. Moreover, she does not contest the fact that the payments were made at $305 per degree, rather than the $145 per degree rate to which claimant was entitled. Although claimant argued at the hearing before the Referee that the payment was "gratuitous," on Board review she refers to the additional $1,200 as "unclassified moneys" and an "erroneous payment." However characterized, claimant does not argue that the amount paid was not "compensation." See ORS 656.005(8).

Therefore, the employer was authorized, pursuant to ORS 656.268(13), to make adjustments in "compensation paid or payable" and offset the amount it had previously paid against claimant's subsequent award. Since we have found the employer's action to be consistent with its statutory authority, we do not consider its conduct to have been unreasonable.

Finally, claimant argues that the employer must request a hearing specifically raising the offset issue in order to obtain authorization for the offset. We disagree.

ORS 656.268(13) does not require an employer or insurer to specifically request a hearing on this particular issue. Likewise, neither OAR 436-60-170 nor OAR 436-30-020(12)(a) have such a requirement. Moreover, we note that the employer did raise this issue in the hearing before the Referee. Accordingly, we reject claimant's argument that the employer is precluded from recovering an offset because it did not specifically request a hearing.

Next, claimant contends that she is entitled to additional scheduled permanent disability for "post surgical weakness in the quadriceps muscle group." She claims that she suffers from a loss of strength not compensated by the rules and she asks the Board to remand to the Director for the adoption of a rule. See ORS 656.726(3)(f)(C); Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

To begin, since claimant did not seek remand until Board review, we are inclined to deny the request as untimely. See Brian G. Vogel, 46 Van Natta 225 (1994) (request for Board reconsideration too late); Kelly D. Mustoe, 46 Van Natta 285 (1994) (no request for remand filed); Michael R. Wickstrom, 46 Van Natta 906 (request for remand to Director made at hearing was timely). Nevertheless, we need not resolve that question because, even if claimant's request was timely, we are not persuaded that remand is warranted.

Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph." Loss of strength for other losses in the leg or foot is rated when there is an injury to unilateral spinal nerve roots or when the cause is peripheral nerve injury. OAR 436-35-230(7) and (8) (WCD Admin. Rules 2-1991). OAR 436-35-230(9) provides that 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." (Although the Referee incorrectly applied the standards found in WCD Admin. Order No. 6-1992, we note that there was no substantive change in the rules; only the numbering changed).

Dr. Utterback, an orthopedist, stated that claimant's "[q]uadriceps strength is approximately 75% of normal." (Ex. 13). Dr. Utterback did not explain why claimant's quadriceps strength was 75 percent of normal and there is no other medical evidence in the record to explain her loss of strength. Dr. Utterback's further comment that claimant "is requested to resume quadriceps strengthening exercises, particularly if she wishes to ski or do similar sports," (Ex. 13), indicates her loss of quadriceps strength may be only temporary. We conclude that claimant has not met her burden of proving that her disability is not addressed by the standards. See ORS 656.266 (claimant has burden of proving nature and extent of any disability). Consequently, we have no authority pursuant to ORS 656.726(3)(f)(C) to remand this case to the Director for the adoption of temporary rules.

ORDER

The Referee's order dated September 23, 1993 is affirmed.

In the Matter of the Compensation of
BARBARA J. FULLER, Claimant
WCB Case No. 93-06700
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order that denied her request for an assessed attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a neck strain. Claimant, through her attorney, filed a request for hearing alleging that SAIF had "de facto" denied a thoracic sprain. At the beginning of the hearing, the Referee stated that "the parties are agreed that claimant's thoracic sprain is part of her accepted September 2, 1991, injury claim." The parties also stipulated that SAIF had timely paid all medical bills and temporary disability related to claimant's cervical and thoracic conditions.

The Referee found that, because SAIF had not expressly denied compensability of the thoracic condition and had paid all compensation in connection with the condition, it had accepted the thoracic condition when it accepted the neck strain. Therefore, finding no denial of compensation, the Referee concluded that claimant's attorney was not entitled to an assessed fee under ORS 656.386(1).

Whether acceptance occurs is a factual issue. SAIF v. Tull, 113 Or App 449, 454 (1992). Furthermore, mere payment of benefits does not constitute acceptance. ORS 656.262(9). Although SAIF paid all compensation, we find no evidence in this case that SAIF accepted a thoracic condition until shortly before the hearing was convened. Under these circumstances, we find that claimant's attorney is entitled to an assessed fee under ORS 656.386(1). See Jones v. OSCI, 108 Or App 230, 232 (1991).

On review, claimant's attorney requests a fee of $2,500. We agree with SAIF that counsel is not entitled to this amount. Although claimant's attorney is entitled to be compensated for those services leading to SAIF's acceptance of the thoracic condition, a fee for services directed at the fee issue at hearing or on review is not warranted. See Amador Mendez, 44 Van Natta 736 (1992).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $250, to be paid by SAIF. In reaching this conclusion, we have particularly considered those services leading to SAIF's acceptance of the thoracic condition (based on the record and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 29, 1993 is reversed. Claimant's attorney is awarded an assessed fee of $250, payable by the SAIF Corporation.

In the Matter of the Compensation of
KATHLEEN M. GLENN, Claimant
WCB Case No. 93-07433
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Lipton's order that affirmed an Order on Reconsideration that increased claimant's unscheduled permanent partial disability related to her left shoulder from 7 percent (22.4 degrees) to 30 percent (96 degrees) and awarded claimant a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability and penalties. We affirm.

FINDINGS OF FACT

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

In lieu of the finding on page 3 of the Opinion and Order stating, "In addition, the reviewer rated claimant's residual functional capacity at medium to light for a value of 3 percent," we find: In addition, the reviewer rated claimant's prior strength as medium and her residual functional capacity as light, for an adaptability factor of 3.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Partial Disability

We adopt the Referee's conclusion regarding extent of permanent partial disability, with the following supplementation.

The insurer argues that the Referee and the Appellate Unit erred in utilizing the medical arbiter's residual functional capacity (RFC) assessment and impairment findings in rating claimant's permanent disability. We disagree.

OAR 436-35-270(3)(d) provides that maximum RFC is the greatest capacity evidenced by: (A) the attending physician's release; (B) the preponderance of the medical opinion, including but not limited to physical and work capacities evaluations; or (C) the strength of any job at which the worker has "returned to work" when RFC is determined. Because claimant's adaptability factor, including her RFC, is to be determined as of the date of the reconsideration order, we may consider the medical arbiter's report in determining claimant's RFC. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993); Ty W. Hawkins, 45 Van Natta 2365 (1993). For the following reasons, we conclude that, whether measured under OAR 436-36-270(3)(d)(A), (B) or (C), claimant's RFC is light.

Claimant compensably injured her left shoulder in November 1992, and eventually required a partial resection of her left clavicle. Following surgery, Dr. Mandiberg, claimant's treating surgeon, released claimant to light duty, and claimant was assigned to a "general help" light duty position. Thereafter, Dr. Mandiberg, released claimant to "regular work", because claimant's light duty position involved repetitive duties that made her shoulder mildly sore, and because claimant believed that her regular job would cause her fewer problems. (Exs. 40-42). Alternatively, Mandiberg released claimant to a light duty processing position. (Ex. 43; see Ex. 41). At the time of her left shoulder injury, claimant's "regular work" was as a packaging technician, which involved medium strength work. (See Exs. 20, 20A, 34). Since her return to work after her surgery, claimant has performed only light work.

The claim was closed by Notice of Closure that assigned an adaptability factor of zero. Claimant requested reconsideration. The Director appointed Dr. Fuller as medical arbiter. After examining claimant, Dr. Fuller concluded that, in view of claimant's left shoulder weakness and decreased range of motion, claimant was able to perform light work. (Ex. 46-4).

The insurer argues that, because Dr. Mandiberg released claimant to "regular work", and because claimant's "regular work" at the time of injury required medium strength, claimant's maximum RFC is medium, in which case claimant's adaptability factor would be zero. See OAR 436-35-310(3). We disagree.

Dr. Mandiberg released claimant to "regular work" because claimant believed that her regular position would cause her fewer shoulder problems than would her light duty position. Because the record establishes that the release was not given on the basis of medical evaluation, but rather was given on the basis of claimant's assessment of her regular and light duty positions, we do not consider the release persuasive evidence that claimant was able to perform her regular duties. See Daniel E. Nelson, 45 Van Natta 415 (1993).

Moreover, in light of the fact that Dr. Mandiberg concurrently released claimant to a light-duty processing position, we conclude that, at most, Dr. Mandiberg released claimant to a light duty position. Therefore, because Dr. Fuller determined that claimant was suited for light work and because claimant returned to work in a light duty position, we conclude that, whether measured by Dr. Mandiberg's release, the preponderance of the medical opinion, or claimant's job strength when RFC was determined, OAR 436-35-270(3)(d)(A)-(C), claimant's maximum RFC was properly rated light. It follows that, because claimant's job strength demands before her shoulder injury were rated medium, her adaptability factor was correctly rated 3. OAR 436-35-310(3).

We turn to the impairment issue. OAR 436-35-007(9) provides, in part, that "[o]n reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of the medical opinion establishes a different level of impairment." See Matthew J. Hilger, 46 Van Natta 718 (April 13, 1994) (where impairment findings submitted by the attending physician and the medical arbiter are in equipoise, the Board will rely on the medical arbiter's findings).

Dr. Fuller evaluated claimant's left shoulder range of motion and muscle strength. He found that claimant had 90 degrees active abduction (palm down) and mild antalgic weakness with testing of the left rotator cuff, grade 5-/5. (Ex. 46-3). In contrast, Dr. Mandiberg only evaluated claimant's left shoulder range of motion. (Ex. 44).

The Order on Reconsideration rated claimant's left shoulder impairment as 12 percent, consisting of 4 percent for loss of abduction, OAR 436-35-330(5); 3 percent for loss of shoulder strength, OAR 436-35-330(19), OAR 436-35-350(3), (5); and 5 percent for the clavicle resection. OAR 436-35-330(13). Because the standards authorize a permanent disability award for loss of shoulder range of motion and strength, as well as resection of the clavicle, we conclude that Dr. Fuller's report most accurately reflects claimant's shoulder impairment. Accordingly, we agree with the Referee that the Appellate Unit properly relied on Dr. Fuller's impairment findings. See OAR 436-35-007(9).

Penalty under ORS 656.268(4)(g)

We adopt the Referee's conclusions affirming claimant's entitlement to a penalty under ORS 656.268(4)(g), with the following supplementation.

The insurer argues that a penalty should not have been awarded because the penalty was based on a medical arbiter's report that was not in existence at the time of claim closure. We disagree. Because the statutory requirements of ORS 656.268(4)(g) have been met, claimant is automatically entitled to a penalty. Steven L. Cline, 46 Van Natta 512 (1994); Kevin Northcut, 45 Van Natta 173 (1993).

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review regarding the permanent disability issue is $1,000, to be paid by the insurer. In reaching this decision, 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. However, claimant is not entitled to an attorney fee for services on review concerning the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated October 21, 1993 is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by the insurer.

In the Matter of the Compensation of
RICHARD E. MOREY, Claimant
WCB Case No. 93-01309
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nichols' order that upheld the insurer's denial of claimant's aggravation claim for his current low back condition. In his appellant's brief, claimant contends that the Referee abused her discretion by admitting Exhibit 37-A (a March 1, 1993 emergency room report) into the record. On review, the issues are evidence and aggravation.

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

Evidence

Claimant argues that the Referee erred in admitting Exhibit 37-A into the record. No objections were made on the record when Exhibits 1 through 40 were submitted. (Tr. 2). Inasmuch as claimant neither raised an objection on the record, nor substantiates his claim that he did in fact object to the exhibit, he has no basis to have the exhibit excluded. Accordingly, we find no abuse of discretion by the Referee in admitting the evidence.

Aggravation

Every aggravation claim has two components: causation and worsening. Both must be established unless one is conceded. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992), aff'd by equally divided court Fitzpatrick v. Beaverton Welding, 127 Or App 560 (1994). Claimant argues that the insurer "waived" the first element of the aggravation claim (i.e., causation) at the commencement of the hearing.

In denying claimant's aggravation claim, the insurer's denial stated as follows: ". . . Medical information resulting from our investigation of your low back problems does not establish a worsening pursuant to ORS 656.273 which would necessitate reopening of your 1/12/92 claim for acute lumbar strain. We are therefore constrained to deny you claim for aggravation." (Ex. 36). While establishing the issues before the Referee at hearing, the parties had the following discourse:

> "Referee: . . . Claimant has requested the hearing on that Denial, alleging, of course, that his condition has aggravated. Is that the only issue you're raising . . .
>
> [Claimant's counsel]: That's correct, Your Honor.
>
> Referee: And it's, further, my understanding that the employer is not raising any cross-issues.
>
> [Insurer's counsel]: That is correct.
>
> Referee: And so it's your understanding that the only issue being raised is claimant's aggravation?
>
> [Insurer's counsel]: Yes." (Tr. 1).

Our review of the insurer's denial does not establish that the insurer conceded the causal relationship between claimant's compensable strain and his current low back problems. Moreover, the opening remarks at hearing clarify that the sole issue was the insurer's denial. Inasmuch as neither the denial nor the insurer's statements at hearing establish that the causation issue had been conceded, we disagree with claimant's contention that the Referee erred in addressing that issue.

In the Matter of the Compensation of
EARL J. PRETTYMAN, Claimant
Own Motion No. 94-0175M
OWN MOTION ORDER ON RECONSIDERATION
Richard Sly, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 6, 1994 Own Motion Order in which we declined to authorize the payment of temporary disability compensation because claimant had not established he was in the work force on January 31, 1994, when his compensable condition worsened requiring surgery. With his request for reconsideration, claimant's attorney submits that claimant is entitled to time loss benefits because claimant was willing to work, but his compensable injury made a work search futile. Claimant's attorney also noted that, although the SAIF Corporation recognizes him as claimant's attorney, he did not receive SAIF's March 16, 1994 recommendation until May 7, 1994.

In order to allow sufficient time for submission of evidence, the Board abated and withdrew its May 6, 1994 order on May 17, 1994, and requested claimant to file evidence with respect to the work force issue within 14 days of the date of the May 17, 1994 order. SAIF was requested to file a response within 14 days of the date of receipt of claimant's response. No response has been received from claimant.

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, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In a May 19, 1994 response to the abatement, SAIF stated that its position remained that claimant had removed himself from the work force. SAIF submitted an undated Employment Department printout which reported "customer record not found" and "all reports bypassed." This printout might indicate that claimant had not applied for any work or unemployment benefits through the Employment Department, however, it would not indicate whether claimant had applied for work through any other channel. SAIF also submitted a July 28, 1992 IME report in which Drs. Geist and Podemski, examining physicians, stated that claimant "last worked seven or eight years ago, and has not been employed since." However, since the report does not address the relevant time period (claimant's January 31, 1994 worsening), we do not find the doctors' remarks persuasive.

In his May 10, 1994 letter, claimant's attorney contends that claimant is "entitled to time loss benefits because, while he is willing to work, his compensable injury has made it impossible for him to obtain and perform any kind of work for which he is qualified by age, education and work experience." Although the Board granted claimant additional time to submit supporting evidence, claimant has not responded with evidence that he was willing to seek work, but unable to work because of the compensable injury. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question. The assertions of claimant's attorney will not suffice as evidence supporting claimant's contentions. Therefore, we continue to find that claimant has not sustained his burden of proving he was in the work force at the time of his disability.

Accordingly, our May 6, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 6, 1994 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES A. RUSSELL, Claimant
WCB Case Nos. 93-10076 & 93-10108
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable left shoulder injury claim. A Determination Order awarded no permanent disability. The Determination Order was affirmed by an Order on Reconsideration.

The Referee rejected claimant's argument at hearing that he proved entitlement to 5 percent unscheduled permanent disability based on a chronic condition. Finding no medical evidence supporting claimant's assertion, the Referee also concluded that claimant should not be awarded any permanent disability. On review, claimant reiterates his contention that he proved impairment based on a chronic condition.

In order to be entitled to unscheduled chronic condition impairment, there must be a preponderance of medical opinion establishing that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). We have interpreted this rule as requiring medical evidence of at least a partial loss of ability to repetitively use a body part. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452, 1453 (1993).

Based on a closing examination, claimant's attending physician, Dr. Lawton, orthopedic surgeon, reported that claimant was medically stationary and "fully recovered from his industrial injury." (Ex. 7-1). Dr. Lawton also noted that claimant had "learned about proper precautions to avoid repetitive abduction type activities[.]" (Id.)

Dr. Lawton subsequently reported to claimant's attorney that claimant's "primary restriction is to avoid repetitive use of his arm in that potential impingment [sic] range (60-120 degrees)." (Ex. 10). Dr. Lawton further indicated that claimant had "no specific limitations in terms of heavy lifting" but that it was "ill-advised for [claimant] to return to work in which he is constantly doing repetitive use through this range either with light or heavy lifting" since "recurrent symptoms would be quite likely." (Id.)

Dr. Dinneen, orthopedist, who performed a medical arbiter examination, found "no objective evidence of any inability to repetitively use the left shoulder" or any other body part due to claimant's industrial accident. (Ex. 11-2). Dr. Dinneen also found "no permanent preclusions from consecutive sitting, standing, or walking or to the kneeling, reaching, twisting, etc., maneuvers." (Id. at 3).

We agree with the Referee that, at most, Dr. Lawton provided evidence that claimant should avoid repetitive activities in order to prevent recurrent symptoms. Dr. Lawton did not indicate that claimant was unable to perform such activities, instead reporting that he was "fully recovered." Dr. Dinneen affirmatively stated that there was no inability to repetitively use the left shoulder.

Therefore, we find that the medical evidence is insufficient to prove entitlement to chronic condition impairment. Donald E. Lowry, supra; Rae L. Holzapfel, 45 Van Natta 1748 (1993) (physicians' recommendations to avoid repetitive activities in order to prevent symptoms was not proof of an inability to repetitively use a body part). Finding no other evidence of impairment, claimant is not entitled to permanent disability.

ORDER

The Referee's order dated December 9, 1993 is affirmed.

In the Matter of the Compensation of
MIREN G. BERECIBAR-BENNETT, Claimant
WCB Case Nos. 92-03533 & 91-16221
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of that portion of Referee Neal's order which affirmed a Director's order finding claimant eligible for further vocational services. Claimant cross-requests review of that portion of the Referee's order which upheld the employer's denial of her request for neck surgery. On review, the issues are vocational rehabilitation and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's factual findings with the following supplementation.

Claimant sustained a compensable injury in May 1982. The claim was initially closed December 22, 1982, and aggravation rights expired December 22, 1987. (Ex. 37).

The employer provided vocational assistance services, including, but not limited to, an Authorized Training Program with the State of Oregon Employment Division as a service representative from March 1988 to December 1988. Upon completion of the program, claimant was hired by the Employment Division in a temporary position. After working 60 days, claimant was laid off due to a reduction-in-force.

On March 14, 1989, the employer sent claimant a "Notice of End of Return-To-Work Assistance," on the ground that her "lack of suitable employment [was] no longer due to the disability caused by the injury." (Ex. 225A).

On October 19, 1989, a Determination Order issued based on claimant's completion of the vocational rehabilitation program. Claimant was found entitled to additional temporary and permanent disability. Her condition was found to have been medically stationary on March 8, 1985, nonstationary on October 21, 1985, and again stationary on June 12, 1989. (Ex. 241).

Claimant requested administrative review of her eligibility for vocational assistance. (See Exs. 244, 249-1). On December 22, 1989, the Director dismissed claimant's request because the employer had agreed, as of December 19, 1989, to provide vocational services and, thus, claimant could not "preserve" her appeal rights past the time the issue was ripe. (Ex. 249).

On December 19, 1989, the employer offered claimant vocational services on an optional basis. (See Exs. 249-1, 270, 273, 274). Claimant began a business course for employment as a receptionist, but this program was found not to be appropriate. (Ex. 273). The employer's vocational counselor recommended reopening the claim for vocational services, because prior services had not been adequate to secure suitable employment. (Ex. 274-1).

On June 8, 1990, the employer issued a Notice of Eligibility for Vocational Assistance. (Ex. 278; see also Ex. 279). The employer provided training from July 30, 1990 until October 5, 1990 to prepare claimant for employment as a travel agent. (Exs. 286, 288). After completing the program, claimant was hired on February 4, 1991 as a travel agent, but she was terminated on March 26, 1991 because she was not qualified.

On May 14, 1991, claimant requested review by the Director.

On October 23, 1991, the Director issued an order finding claimant entitled to additional vocational services, ordering the employer to restore claimant's vocational eligibility and complete a vocational evaluation within 90 days. (Ex. 316AA). The Director concluded that claimant's eligibility for additional vocational services "arises out of the medically non-stationary date of October 21, 1985.

Therefore, for vocational eligibility purposes, [claimant] is not considered to be in [the Board's Own Motion] status and retains entitlement to seven months of training time, if necessary, to obtain skills which will enable her to obtain suitable employment." (Ex. 316AA-5).

The employer requested review of the Director's order.

Meanwhile, the employer initiated the vocational evaluation process ordered by the Director. (Ex. 316A).

On March 9, 1992, claimant's treating physician advised that she was not medically able to participate in the vocational evaluation. (Ex. 324).

On April 8, 1992, the employer issued a Notice of End of Return-to-Work Assistance, on the ground that claimant's "lack of suitable employment cannot be resolved by currently providing vocational assistance." The employer also advised claimant that she may request restoration of eligibility pursuant to OAR 436-120-055(1). (Ex. 327).

CONCLUSIONS OF LAW AND OPINION

We agree with the Referee's order affirming the Director's 1991 vocational assistance order, based on the following reasoning.

We adopt and affirm that portion of the Referee's order holding that principles of res judicata do not bar the 1991 Director's order. The 1989 Director's order dismissed claimant's appeal because the employer agreed to provide vocational services at that time. Issue preclusion does not apply because claimant's appeal of the March 1989 termination notice was never litigated. See Drews v. EBI Companies, 310 Or 134, 139-40 (1990). Nor does claim preclusion bar the 1991 Director's order, since the current claim is not based on the same factual transaction that was at issue in 1989, and the current claim could not have been joined in the 1989 action. Id. at 140-41. In other words, claimant could not have litigated the current claim in 1989, because it is based on events that transpired after the 1989 Director's order. Accordingly, we agree with the Referee's determination that principles of res judicata do not bar the Director's 1991 order.

We turn now to the merits of the Director's 1991 order. The Director's vocational assistance order may be modified only if it: (1) violates a statute or rule; (2) exceeds the agency's statutory authority; (3) was made upon unlawful procedure; or (4) constitutes an abuse of discretion. ORS 656.283(2).

Here, the employer points to no violation of rule or statute or any unlawful procedure, nor does the employer contend that the Director's order constituted an abuse of discretion. Thus, there is no apparent basis for modifying the Director's order. Furthermore, we agree with the Referee's reasoning that the Director may order redetermination of eligibility pursuant to OAR 436-120-055. In addition, pursuant to OAR 436-120-210(7), the Director may order the insurer to provide specified vocational assistance at any time, in order to achieve compliance with the Workers' Compensation Law. The Director did so in this case. Accordingly, we find no basis for modifying the Director's order.

The employer's arguments on review do not persuade us otherwise. As discussed above, we find that the 1991 Director's order was not barred by principles of res judicata.

The employer also argues that the Director erred in finding claimant's eligibility for additional vocational services arises out of her October 1985 medically non-stationary date. Instead, the employer contends that claimant's eligibility for vocational services relates back to June 1990 when the employer voluntarily restored claimant's eligibility for vocational services, and her eligibility should be determined based on circumstances at that time. See Employer's Reply Brief at 1.

The employer's argument does not persuade us that the Director erred, inasmuch as its argument logically leads to the same conclusion the Director made; i.e., that claimant's vocational eligibility arises out of the October 1985 non-medically stationary date. The employer restored claimant's eligibility in June 1990 based on its vocational counselor's recommendation following a

brief and inappropriate training program. That training program was the one the employer offered in December 1989, as a result of claimant's appeal of the March 1989 termination of eligibility. That termination occurred during the October 1985 medically non-stationary period. Thus, the restoration of eligibility in June 1990, which the employer contends should be the basis for the Director's 1991 order, arose directly out of the last opening of the claim (i.e., the October 1985 medically non-stationary date) and before the beginning of the Board's Own Motion jurisdiction. See Coombs v. SAIF, 39 Or App 293, 298 (1979).

We conclude that the employer's argument actually supports rather than undermines the Director's reasoning. Accordingly, we find no error in the Director's finding that claimant's eligibility for additional vocational services arises out of the medically non-stationary date of October 21, 1985. (Ex. 316AA-5). Consequently, we also find no error in the Director's determination that, for vocational eligibility purposes, claimant is not in Own Motion status. (Id.); Coombs v. SAIF, supra. Therefore, because claimant's entitlement to vocational services arises out of a pre-Own Motion opening of her claim, the Director's order does not contravene ORS 656.278. Compare Harsh v. Harsco Corporation, 123 Or App 383 (1993) (claimant not entitled to vocational assistance when claim is in "own motion" status). Accordingly, we affirm the Director's 1991 vocational assistance order.

We also affirm and adopt that portion of the Referee's order which upheld the employer's denial of claimant's request for neck surgery.

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 vocational services issue is $500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 24, 1993 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
LINDA K. ENNIS, Claimant
WCB Case No. 93-07669
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband, and Haynes.

Claimant requests review of those portions of Referee Howell's order which: (1) declined to award an assessed attorney fee under ORS 656.386(1); and (2) declined to award a penalty and attorney fee for an allegedly unreasonable denial of claimant's bilateral carpal tunnel syndrome. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

ORS 656.386(1) Attorney Fee

In 1986, claimant developed a compensable bilateral carpal tunnel syndrome that the SAIF Corporation accepted and processed to closure in 1987. Following claim closure, claimant continued to experience symptoms for which she periodically sought conservative treatment. In 1990, she began working for another employer. On March 1, 1993, she consulted her treating physician, Dr. Buchholz, requesting medication. SAIF sought clarification from Dr. Buchholz of the causal connection between claimant's current carpal tunnel condition and her original accepted claim. Dr. Buchholz wrote that claimant's current employment "may have" substantially aggravated her carpal tunnel condition. (Ex. 24).

After receiving Dr. Buchholz's May 7, 1993 letter, SAIF issued a denial and disclaimer of responsibility for claimant's current bilateral carpal tunnel condition on the grounds that her current employment was the major contributing cause of her need for medical treatment. Claimant did not file a claim against her current employer, however.

At hearing, SAIF conceded that claimant's carpal tunnel condition was compensable. The Referee found that SAIF was still responsible for claimant's current bilateral carpal tunnel syndrome and set aside its denial. The Referee refused, however, to award an assessed attorney under ORS 656.386(1), citing Multnomah County School District V. Tigner, 113 Or App 405 (1992).

In Tigner, the court indicated that a carrier-paid attorney fee is not authorized under ORS 656.386(1) when a denial of compensability is withdrawn before hearing, but a hearing is still held on responsibility. In Penny L. Hamrick, 46 Van Natta 14, 16 (1994), we interpreted the aforementioned portion of Tigner as dicta. We concluded that a claimant is entitled to a carrier-paid attorney fee under ORS 656.386(1) when there is a withdrawal of the compensability portion of a denial prior to a hearing on the issue of responsibility. 46 Van Natta at 16. Subsequently, in Dale Karstetter, 46 Van Natta 147, 148 (1994), we held that an assessed attorney fee under ORS 656.386(1) was appropriate when compensability denials were withdrawn after the first hearing but before the continued hearing.

Likewise, in this case, claimant is entitled to an attorney fee under ORS 656.386(1) because SAIF issued a denial of compensation and did not concede the issue of compensability until the hearing. Although SAIF contends that it never denied compensability, we are persuaded that its "Disclaimer of Responsibility and Claim Denial" created an issue of compensability regarding claimant's current bilateral carpal tunnel condition. The letter stated that SAIF had not requested designation of a paying agent and it contained "notice of hearing" provisions consistent with a denial of compensation. (Ex. 25). Finally, the denial letter stated that it was a denial of a claim for benefits. See Johnny M. Davis, 45 Van Natta 2282, 2283 (1993) (responsibility disclaimer raised compensability issue where letter stated it was a denial of claim for benefits and contained notice of hearing provisions).

Inasmuch as we find that claimant's attorney was instrumental in securing the rescission of a compensability denial without a hearing, we hold that claimant is entitled to an insurer-paid attorney fee award under ORS 656.386(1). After considering the factors in OAR 438-15-010(4) and applying them to this case, we find that $1,000 is a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Unreasonable Denial

The Referee refused to award a penalty and attorney fee, finding that SAIF had a legitimate doubt about its liability for claimant's medical services when it issued its denial. Specifically, the Referee found that SAIF plausibly interpreted Dr. Buchholz's May 7, 1993 medical report as indicating that claimant's current employment was the "major contributing cause" of her need for medical treatment. Thus, according to the Referee, SAIF had a reasonable belief that it was not responsible for claimant's current bilateral wrist condition. We disagree.

A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the insurer at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Nowhere in Dr. Buchholz's May 7, 1993 medical report is there a statement that satisfies the major causation standard. The Referee cited Dr. Buchholz's comment that claimant's current employment "may have" substantially aggravated her carpal tunnel condition. However, this comment was couched in terms of medical possibility, not probability. Thus, it does not establish causation, even assuming it otherwise satisfied the major causation standard. Raymond E. Meredeth, 46 Van Natta 431, 433 (1994).

Dr. Buchholz also stated that claimant's employment "could" exacerbate her condition, but that statement is also too speculative to have justified a denial. Id. Finally, Dr. Buchholz wrote that claimant's work was "substantially and immaterially [sic]" contributing to her symptoms. While this comment would satisfy a material causation standard, it does not establish that claimant's current employment was the "major contributing cause" of her current condition or its worsening as required by ORS 656.802. We note that SAIF neither sought clarification from Dr. Buchholz nor another opinion regarding the major causation issue prior to issuing its denial. It just denied the claim based on a medical report that was mostly speculative and that established, at best, only material causation.

Accordingly, we are not persuaded that SAIF had a reasonable belief that it was not responsible for claimant's current medical services. SAIF contends, however, that, when it issued its May 1993 denial, material causation was the applicable legal standard in responsibilty cases. See SAIF v. Drews, 117 Or App 596 (1993).

Although SAIF's denial was issued prior to the Supreme Court's decision in SAIF v. Drews, 318 Or 1 (1993), which applied a major causation standard to responsibility cases, we still find that the applicable legal standard was "major contributing cause." When SAIF issued its denial, there was no indication that claimant had experienced a new injurious event during a discrete period. See Valtinson v. SAIF, 56 Or App 184, 188 (1982). When seen by Dr. Buchholz in March 1993, claimant was merely seeking additional medication. (Ex. 24, Tr. 10). There was no indication of a significant change in her condition according to her electrical studies. (Ex. 24).

In the absence of evidence from which it could reasonably conclude that claimant suffered a "new injury," to shift responsibility, SAIF needed medical evidence that claimant had sustained a new occupational disease, i.e., that her subsequent employment was the major contributing cause of a worsening of her underlying bilateral carpal tunnel condition. See Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993). The court had issued its decision in Senters prior to SAIF's denial. Since Dr. Buchholz's medical report could only be reasonably interpreted as establishing material, as opposed to major, causation, SAIF's denial was unreasonable.

Thus, we conclude that claimant is entitled to a 25 percent penalty under ORS 656.262(10) based on all amounts of compensation, including medical services, due at the time of the hearing as a result of the Referee's order. Ben G. Santos, 44 Van Natta 2228 (1992), on recon 44 Van Natta 2385, 2386 (1992). The penalty is to be shared equally by claimant and his attorney.

ORDER

The Referee's order dated October 13, 1993 is reversed in part and affirmed in part. Those portions which declined to award penalties and attorney fees are reversed. Claimant is awarded an assessed attorney fee of $1,000 under ORS 656.386(1) for her counsel's services regarding the compensability issue, to be paid by SAIF. For SAIF's unreasonable denial of claimant's carpal tunnel syndrome, claimant is awarded a 25 percent penalty based on all compensation due at the time of hearing as a result of the Referee's order, to be shared equally by claimant and her attorney. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting.

The majority concludes that SAIF's denial was unreasonable. I disagree.

While Dr. Buchholz's May 7, 1993 medical report is far from a model of clarity, I still believe that it gave SAIF a legitimate basis on which to deny responsibility for this claim. This is especially true when claimant had gone at least two years without medical treatment and was working in a new job that involved intensive hand and wrist use. Under these circumstances, SAIF reasonably believed that it could shift responsibility to the subsequent employer. Therefore, I would affirm the Referee's decision on this issue.

Accordingly, I dissent.

In the Matter of the Compensation of
MICHAEL J. GALBRAITH, Claimant
WCB Case No. C4-00797
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Julene Quinn (Saif), Defense Attorney

On March 29, 1994, 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.

By order dated May 11, 1994, we approved the parties' CDA. Our order also approved an attorney fee, payable to both claimant's former and current counsel. Our order reasoned that, because claimant's current counsel conceded that former counsel was entitled to an attorney fee of $1,200, and based upon former counsel's billing statement referencing services pertaining to settlement negotiations, former counsel had rendered services pertaining to the CDA, on behalf of claimant. Consequently, we directed the SAIF Corporation to make the entire CDA attorney fee of $7,475 payable to both claimant's former and current counsel.

Claimant has requested reconsideration of our order. Claimant's request for reconsideration was filed on May 19, 1994. Thus, we find claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we withdraw our prior order.

On reconsideration, claimant argues that our order approving the CDA should not have ordered the entire sum of $7,475 to be paid jointly to both former and current counsel. Claimant contends that, because claimant's former counsel has only asserted a lien for the amount of $4,000, the remaining $3,475 is not in dispute and should be paid directly to claimant's current counsel alone.

Claimant's former counsel has submitted a response to claimant's request for reconsideration. Claimant's former counsel states that her lien was originally on the entire attorney fee "or a settlement of $4,000." Claimant's former counsel requests that we adhere to our prior order.

On reconsideration, we agree with claimant's current counsel. After reviewing the prior correspondence submitted by claimant's former counsel, we find that former counsel's representations that she was "willing to compromise our bill to $4,000," constituted a lien asserted in the amount of $4,000. Accordingly, because former counsel has only alleged an entitlement to $4,000 of the attorney fee payable from the CDA proceeds, the remaining $3,475 is not in dispute. Accordingly, we herein modify our prior order.

On reconsideration, we direct SAIF to pay claimant's current counsel an attorney fee in the amount of $3,475 from the CDA proceeds. Consistent with our prior order, the remaining $4,000 shall be paid jointly to both claimant's current and former counsel. We reiterate that our order does not constitute a decision regarding the amount of attorney fees to which former counsel is entitled. Rather, we take this action to resolve this matter in the most expedient manner possible.

Accordingly, on reconsideration, as modified herein, we republish our May 11, 1994 order.

IT IS SO ORDERED.

Board Chair Neidig specially concurring.

As stated in my prior concurring opinion, I would approve this CDA and an attorney fee, with the entire amount payable to claimant's current counsel, who is the counsel of record in this case. I, therefore, continue to respectfully disagree with the majority's position that a portion of the attorney fee should be paid jointly to claimant's current and former counsel.

In the Matter of the Compensation of
JANICE M. HUNT, Claimant
WCB Case No. 93-07847
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Crumme's order that: (1) set aside a Determination Order that had declined to reclassify claimant's post traumatic stress disorder claim from nondisabling to disabling; and (2) directed the insurer to reclassify claimant's claim as disabling. Claimant has moved to dismiss the insurer's request for review on the ground that, after it filed the request for review, the insurer formally accepted claimant's claim as disabling. On review, the issues are dismissal and reclassification. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Subsequent to the insurer's filing of its request for review, the insurer issued a Notice of Acceptance of claimant's condition as disabling. The same day, it also issued a "1502" form indicating that it had accepted claimant's condition as disabling, but that it had appealed the Referee's order. The form was copied to claimant.

Relying on Pamela S. Cheney, 44 Van Natta 2100, on recon 44 Van Natta 2277 (1992), claimant has moved to dismiss the insurer's request for review. In Cheney, after the insurer appealed a prior referee's order setting aside its compensability denial of the claimant's low back condition, the insurer formally accepted the low back condition. We held that, because the insurer's acceptance was inconsistent with its assertion of noncompensability, and was not required by rule or statute, the insurer's acceptance included the claimant's low back condition. Id. at 2101.

Claimant argues that this case is analogous to Cheney because, while the Referee's order was on review, the insurer issued a "Notice of Acceptance" of claimant's claim as disabling. Therefore, claimant argues, because no statute or rule requires the issuance of a notice of acceptance under the circumstances of this case, the insurer's acceptance is inconsistent with and supersedes its request for review. We disagree.

In Cheney, the issue was compensability, whereas here, the issue is reclassification. Specifically, in Cheney, the claimant's condition was in a denied status until the insurer issued its Notice of Acceptance. Here, in contrast, the insurer had, prior to this litigation, already accepted claimant's condition, but had classified it as nondisabling. On that ground alone, we find Cheney distinguishable.

Furthermore, when the insurer issued the Notice of Acceptance, it also issued a "1502" form that apprised claimant that it was appealing the Referee's order requiring it to reclassify claimant's claim. Because the insurer simultaneously notified claimant of its intent to challenge the classification issue and of its acceptance of claimant's claim as disabling, we conclude that the insurer's Notice of Acceptance, although not specifically required by rule or statute, was not inconsistent with its assertion that claimant's condition was nondisabling. Moreover, its announcement was consistent with the Referee's directive to process the claim as disabling. Accordingly, we deny the motion to dismiss.

Reclassification

We adopt and affirm the Referee's conclusions regarding reclassification, with the following supplementation.

Claimant testified that she was unable to work between December 11 and December 17, 1991, because of stress related to her work activities. (See Tr. 10-13). Because that testimony is uncontroverted and is supported by the medical record, (Ex. 6-1), we find that claimant was temporarily disabled during that time. Donald R. Dodgin, 45 Van Natta 1642, 1645 (1993). Furthermore, because claimant was temporarily disabled for more than three days, she is entitled to temporary disability compensation. ORS 656.210(3).[1] Accordingly, we agree with the Referee that claimant's claim should be reclassified as disabling. See ORS 656.005(7)(c); OAR 436-30-045(5)(a).

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review regarding the reclassification issue is $1,350, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 1, 1993 is affirmed. For services on Board review, claimant's counsel is awarded $1,350, to be paid by the insurer.

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[1] The insurer argues that, because claimant's treating physician never authorized time loss benefits, claimant is not entitled to time loss benefit for December 11 through December 17, 1991. That argument fails to recognize that, with respect to this claim, claimant first sought medical treatment on December 17, 1991. (Ex. 2). Thereafter, one of claimant's physicians acknowledged that claimant had missed work for five days because of her stress condition. (Ex. 6-1). The insurer does not dispute that evidence. Under the circumstances, we do not construe a physician's declining to authorize time loss after claimant sought treatment as making any comment on claimant's entitlement to time loss before she sought treatment.

In the Matter of the Compensation of
JENNIFER KAMMERER, Claimant
WCB Case No. 93-05996
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband, and Hall.

Claimant requests review of Referee Davis' order that: (1) upheld the insurer's denial of claimant's right eye injury claim; and (2) did not award penalties for an allegedly unreasonable denial. On review, the issues are whether claimant's injury arose out of and in the course and scope of employment and penalties.

We adopt and affirm the Referee's order. See Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994); Heath A. Nickel, 44 Van Natta 1171 (1992).

ORDER

The Referee's order dated September 20, 1993 is affirmed.

Board Member Hall, dissenting.

Although I agree with the majority's finding that claimant's injury occurred "in the course of" employment, I would also find that her injury "arose out of" employment, and is, therefore, compensable. Accordingly, I respectfully dissent.

Claimant was an innocent bystander and victim of actions by a co-worker. As a nonparticipant, neither "horseplay" or "assault" analyses should apply. Rather, the traditional unitary work connection analysis controls. In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Supreme Court explained that in evaluating the work connection of an injury, both the "arising out of" and "in the course of" elements of the test must be considered; neither is dispositive. Each element is part of a single inquiry; that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Id. at 366; Rogers v. SAIF, 289 Or 633 (1980).

Here, the "in the course of" employment element is easily met. Claimant was injured while walking through an employer controlled parking lot on her way to another parking lot where she was required, by the employer, to park her car. See Norpac Foods, Inc. v. Gilmore, supra; SAIF v. Marin, 128 Or App 161 (1994).

As to the "arising out of" element, one must wonder if this claim would even be before the Board had claimant's injury occurred moments earlier (i.e., "on the job" within the walls of the employer's plant). Claimant was injured when a co-worker "flicked" a plastic bagging tag which hit her in the eye. The plastic tags are about two inches by three inches in size and resemble tabs used to close the plastic bag around a loaf of bread. These plastic tags are used by the employer, and their intended use is for the benefit of the employer. The "instrument of injury" was inherent in the workplace. Claimant's injury was caused by one of these "instruments" (tools).

That the injury occurred in the parking lot does not negate the fact that the risk of injury was inherent in claimant's workplace. This risk of injury from the use or misuse of this instrument did not abruptly terminate at the plant door. I find the risk of injury sufficiently connected to claimant's employment, thus establishing the "arising out of" element.

The co-worker's misuse of the plastic tag does not take the injurious act outside the scope of employment. The job environment enhanced the risk of injury. It was commonplace for fellow workers to fling tags. The tags were often flung both inside the employer's plant as well as in the employer's parking lot. As such, this activity was a risk inherent in claimant's employment. Moreover, the majority has found the claim not compensable, in part, because of the fault of the co-worker. By doing so, the majority is injecting fault into a no fault system.

In the Matter of the Compensation of
DEBRA L. ROLLINI, Claimant
WCB Case No. 93-04495
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Myzak's order that: (1) affirmed claimant's medically stationary date of June 23, 1992, as determined by the Order on Reconsideration; (2) affirmed claimant's scheduled permanent disability award of 22 percent (33 degrees) for a right leg (knee) injury, as determined by the Order on Reconsideration; (3) ordered payment of a penalty as awarded by a prior referee; and (4) assessed a penalty of 25 percent of the unpaid penalty amounts awarded by a prior referee. On review, the issues are medically stationary date, temporary disability compensation, extent of scheduled permanent disability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

We adopt and affirm the Referee's opinion on this issue.

Temporary Disability Compensation

We adopt and affirm the Referee's opinion on this issue.

Extent of Scheduled Permanent Disability

We affirm the Referee's opinion on this issue, with the following supplementation.

The employer contends that claimant's scheduled permanent disability should be reduced to 8 percent on the basis that the arbiter provided no objective evidence of impairment. We disagree.

Findings concerning the worker's impairment can be made only by the medical arbiter, the attending physician at the time of claim closure, or another physician's findings if concurred in by the attending physician. Furthermore, unless a preponderance of the evidence from the attending physician indicates otherwise, the arbiter's report is to be used to rate permanent disability. ORS 656.245(3)(b)(B); OAR 436-35-007(8) and (9); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994); see also Edward M. Johnston, 45 Van Natta 1165 (1993).

Here, Dr. Strum, claimant's attending physician, did not concur in the report by Dr. Utterback, the insurer's examiner. Consequently, the examiner's findings cannot be considered. Furthermore, although Dr. Stanford, the medical arbiter, indicated that he was unable to diagnose pathology that would explain claimant's diminished range of motion, he did not indicate that his range of motion findings were unreliable. We consequently use the arbiter's impairment findings to establish claimant's scheduled permanent disability.

Dr. Stanford found reduced range of motion of the right knee as compared to the left. Claimant retains 90 degrees of flexion in the right knee as compared to 137 degrees in the left for a value of 19 percent, and 22 degrees of extension in the right knee as compared to 0 degrees in the left for a value of 9 percent. OAR 436-35-007(15) and (16); 436-35-220(1) and (2). These values are added (not combined) for a total impairment value of 28 percent of the leg (knee). OAR 436-35-220(4). However, since claimant did not request an increase in scheduled permanent disability, the Referee's affirmance of the 22 percent awarded by the Order on Reconsideration will be left undisturbed.

Penalties and Attorney Fees

The employer accepted claimant's right knee injury claim as disabling. On October 31, 1991, the employer issued a "back-up" denial and stopped paying temporary disability benefits. On September 15, 1992, a prior referee issued an order setting aside the denial and assessing a 25 percent penalty on "amounts then due" as of the date of the May 22, 1992 hearing for the employer's refusal to disclose discoverable documents timely. This order was affirmed by a May 25, 1993 Order on Review, which became final. Debra L. Rollini, 45 Van Natta 960 (1993). The employer paid temporary disability through December 4, 1991 (the medically stationary date found by a Notice of Closure) and a penalty based on that amount.

The Referee ordered enforcement of the prior referee's penalty clause. The Referee then awarded a penalty equal to 25 percent of the penalty due as of the date of the prior hearing for the employer's failure to fully pay the penalty after the prior order was affirmed by the Board.

The employer does not contest its obligation to pay the penalty assessed by the earlier referee's order. However, it challenges the Referee's penalty assessment based on the earlier referee's penalty award. We reverse the Referee's assessment of an additional penalty.

ORS 656.262(10)(a) provides in pertinent part: "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, * * * , the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due." A penalty is not compensation. See Saxton v. SAIF, 80 Or App 631 (1986).

Consequently, no penalty can be assessed pursuant to ORS 656.262(10) for the employer's failure to fully pay the penalty due pursuant to the prior referee's order. James C. Ingram, 41 Van Natta 2417 (1989). Likewise, the employer's failure to fully and timely pay the penalty does not constitute an unreasonable resistance to the payment of compensation. Id. Accordingly, the Referee's penalty assessment is reversed and claimant is not entitled to an attorney fee award under ORS 656.382(1).

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the medically stationary, temporary disability and permanent disability issues is $150, 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 October 4, 1993 is affirmed in part and reversed in part. That portion of the order that assessed a penalty on unpaid penalty amounts is reversed. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $150, to be paid by the self-insured employer.

In the Matter of the Compensation of
DAVID J. ROWE, Claimant
WCB Case Nos. 93-04188, 93-03665 & 93-03666
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Bethlahmy's order that declined to award claimant's counsel an attorney fee pursuant to ORS 656.386(1). Alternatively, claimant argues that the Referee erred in refusing to postpone or continue the hearing for issuance of an order pursuant to ORS 656.307. The SAIF Corporation cross-requests review of that portion of the Referee's order that assessed a penalty-related attorney fee of $300 for each of SAIF's two denials of the compensability of claimant's bilateral carpal tunnel syndrome (CTS). On review, the issue is attorney fees and, alternatively, whether the Referee abused her discretion in refusing to postpone or continue the hearing. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee pursuant to ORS 656.386(1)

The Referee found that, since SAIF did not deny compensability, claimant's counsel was not entitled to a fee pursuant to ORS 656.386(1). We disagree.

ORS 656.386(1) provides, in part, "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." We have held that a claimant's counsel is entitled to a carrier-paid attorney fee under that statute when a carrier rescinds the compensability portion of its denial prior to a hearing regarding responsibility for the claim. Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994); see Dale A. Karstetter, 46 Van Natta 147 (1994).

Because SAIF conceded the compensability of claimant's carpal tunnel syndrome immediately before the hearing regarding the responsibility for that condition, under Hamrick, claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 656.386(1).

SAIF argues that, because its counsel "specifically stated [before hearing] that SAIF [had] never denied compensability and that its denials were limited to responsibility[,]" (SAIF's Respondent's Brief at 3), ORS 656.386(1) does not apply. We disagree.

SAIF issued denials on behalf of two of claimant's former employers. Both of those denials are entitled, "DISCLAIMER OF RESPONSIBILITY AND CLAIM DENIAL." (Exs. 13, 15). Moreover, both denials state, "We have reviewed the information in your file and find that your work activities at [SAIF's insured] are not the major contributing cause of your current condition and need for treatment." (Exs. 13, 15).

The Court of Appeals has held that "[carriers] are bound by the express language of their denials[.]" Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993). Therefore, testimony regarding the purported meaning of a carrier's written denial is irrelevant. See id. at 351-52.

Here, the titles of SAIF's denials reveal that SAIF intended to disclaim responsibility and to deny claimant's claim. More importantly, the denials also expressly denied that claimant's current condition is related, in major part, to claimant's work activities at SAIF's insureds. Read as a whole, the denials can mean only one thing: SAIF intended to deny the compensability of, as well as responsibility for, claimant's current condition. Accordingly, we conclude that SAIF's counsel's

representations regarding SAIF's intent to deny only responsibility for claimant's CTS are irrelevant. Tattoo v. Barrett Business Service, supra, 118 Or App at 351-52.[1]

OAR 438-05-053 supports this conclusion. Subsection (4) of that rule provides that "[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 divisions: 'THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS. * * *'" OAR 438-05-053(4) (emphasis added). In contrast, subsection (3) of the rule provides that "[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. * * *'" OAR 438-05-053(3) (emphasis added).

Both of SAIF's denials contain bold-face paragraphs that begin, "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS," and include the language expressly required by OAR 438-05-053(4) in the case of a disclaimer of responsibility that is coupled with a denial of compensability. (Exs. 13-1, 15-1).[2] For this additional reason, we conclude that SAIF denied the compensability of, as well as the responsibility for, claimant's CTS. See Johnny M. Davis, 45 Van Natta 2282 (1993).[3]

To reiterate, under Hamrick, claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 656.386(1) for her counsel's efforts in obtaining the withdrawal of the compensability portion of SAIF's denials prior to hearing. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning the rescission of the compensability denials is $1,000 for each of the two denials, to be paid by SAIF. In reaching these conclusions, we have particularly considered the time devoted to the rescission issues (as represented by the record), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services concerning the attorney fee issues in this case. Martin E. Mendez-Equibel, 45 Van Natta 959 (1993); see Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Because we have ruled in claimant's favor on his arguments under ORS 656.386(1), we do not reach claimant's alternative argument regarding the Referee's refusal to postpone or continue the hearing for issuance of an order pursuant to ORS 656.307.

Penalty-Related Attorney Fee -- SAIF's Denials

We adopt the Referee's conclusion regarding the unreasonableness of SAIF's denials of the compensability of claimant's condition, with the following supplementation.

SAIF's only argument on review in opposition to the Referee's assessment of a penalty-related attorney fee for its unreasonable denials of the compensability of claimant's condition is that it did not deny the compensability of that condition. Because we have rejected that argument earlier, we need not consider it again.

ORDER

The Referee's order dated July 14, 1993 is affirmed in part and reversed in part. For pre-hearing services regarding the compensability issue, claimant's counsel is awarded $1,000 for each of the two denials, to be paid by the SAIF Corporation on behalf of each of its insureds. Otherwise, the Referee's order is affirmed.

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[1] As support for its argument that claimant's counsel is not entitled to an attorney fee under ORS 656.386(1), SAIF also relies on John L. Law, 44 Van Natta 1619 (1992), where we held that ORS 656.386(1) does not authorize an attorney fee award where an insurer rescinded the compensability portion of its denial before hearing and a hearing is held on the merits. Subsequent to the briefing of this case, we issued our decision in Penny L. Hamrick, supra, which expressly disavowed John L. Law. Accordingly, SAIF's argument fails.

[2] The other insurer's disclaimer of responsibility tracked the language set forth in OAR 438-05-053(3), which governs notices of intent to disclaim responsibility only. (Ex. 10).

[3] In his reply brief, claimant argues that, because SAIF did not request review or cross-request review from the Referee's finding that SAIF denied the compensability of claimant's CTS, that finding has become final by operation of law, and is now law of the case. That argument is not well-taken, because it fails to take into account the fact that this Board reviews referee orders de novo, and makes its own findings of fact. See, e.g., Jill M. Meeuwsen-Moore, 42 Van Natta 1332, 1333 (1990).

In the Matter of the Compensation of
SUSAN M. SANCHEZ, Claimant
WCB Case No. 93-04077
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Claimant requested reconsideration of our April 21, 1994 Order on Review. On May 20, 1994, we abated the order to consider the motion for reconsideration and granted an opportunity for the SAIF Corporation to respond. Having received SAIF's response, we proceed with our reconsideration.

In our original order, we reversed the Referee's order setting aside the SAIF Corporation's denial of claimant's occupational disease claim for right carpal tunnel syndrome. Claimant asserts that there is no substantial evidence to support our finding that her right carpal tunnel syndrome is not compensable. Specifically, Claimant objects to the following portion of our order:

> "Dr. Nagel never testified that the symptoms of carpal tunnel syndrome are the disease. Also, Dr. Nagel never explained what was meant by 'passive contributor.' We are very reluctant to accord much significance to this testimony where claimant's counsel used this terminology and Dr. Nagel never explained its meaning."

Citing a lengthy portion of Dr. Nagel's deposition, claimant contends that we cannot justify the above-quoted findings in light of Dr. Nagel's testimony. After having reconsidered Dr. Nagel's testimony, we continue to adhere to the reasoning in our original order.

Moreover, an additional basis for our decision not cited by claimant was Dr. Nagel's testimony that scar tissue from claimant's previous noncompensable surgery is the "major contributing cause" of her current need for surgery. (Ex. 41-8). In light of that testimony, we cannot conclude that scar tissue was merely a "passive contributor." Therefore, even assuming that the symptoms of claimant's carpal tunnel syndrome are the disease (a fact that this medical record does not sufficiently establish), we would still conclude that the noncompensable scar tissue is the major contributing cause of claimant's symptoms, based on Dr. Nagel's unambiguous testimony.

We reiterate that we are not departing from the well-established precedent in Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990) and Georgia Pacific Corp. v. Warren, 103 Or App 275 (1990). However, based on this record, the major contributing cause of claimant's current carpal tunnel condition is the scar tissue resulting from the noncompensable surgery. Accordingly, this claim is not compensable.

On reconsideration, as supplemented herein, we adhere to and republish our April 21, 1994 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
LESTER E. SAUNDERS, Claimant
WCB Case No. 92-14540
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of Referee Peterson's order that: (1) upheld the SAIF Corporation's denial of treatment for claimant's right coronary artery disease and related surgery; (2) declined to assess a penalty and fee for an allegedly unreasonable denial of that condition; and (3) declined to assess a penalty and fee for an alleged discovery violation. The issues on review are res judicata, scope of acceptance, penalties and attorney fees. Claimant moves the Board to remand this case for consideration of additional evidence. Claimant also asks the Board to consider an untimely filed reply brief. We deny claimant's motions and affirm.

FINDINGS OF FACT

Claimant had coronary artery disease (CAD) prior to 1975. He experienced a myocardial infarction (MI) while working for SAIF's insured on March 4, 1975. Claimant sought medical treatment and was diagnosed with CAD and an anterior wall myocardial infarction affecting the left coronary artery. He filed a claim for "coronary heart disease with infarction (anterior)" which SAIF denied. (Ex. 1, 3).

In a final Opinion and Order issued on January 15, 1976, Referee Fink concluded that the "myocardial infarction [claimant] suffered March 4, 1975 is compensable." The opinion made no mention of claimant's underlying CAD. (Ex. 8).

On January 23, 1976, SAIF issued a written notice of claim acceptance. (Ex. 9). The acceptance did not specify the condition being accepted, but did contain the code numbers "801, 995." These were code numbers used generally by SAIF to identify a variety of diseases affecting the functioning of the circulatory system, including MI and CAD. (Ex. 170, Tr. 102-119).

Claimant received conservative treatment but continued to experience chest pain and shortness of breath. On November 3, 1976, he underwent bypass surgery of the left anterior coronary artery. (Ex. 21). SAIF provided benefits for this surgery and claimant's ensuing convalescence. Claimant was initially free of chest symptoms following surgery. However, after a few months he began experiencing periodic chest symptoms. (Ex. 25). His claim was closed in February 1979 with an award of permanent total disability. (Ex. 48). SAIF did not challenge that award and commenced permanent total disability payments.

Claimant's chest symptoms gradually worsened over the next eight years. (Ex. 148). He received treatment for his symptoms on numerous occasions. SAIF paid for this treatment. In July 1992, diagnostic studies verified that claimant had developed significant disease of the right coronary artery and one of its branches. (Ex. 108). On August 5, 1992, claimant underwent bypass surgery of the right coronary artery. (Ex. 118). On November 3, 1992, SAIF issued a denial of treatment for claimant's right CAD. (Ex. 144). Claimant requested a hearing from this denial.

FINDINGS OF ULTIMATE FACT

This record has not been improperly, incompletely or otherwise insufficiently developed or heard by Referee Peterson.

Compensability of claimant's current right CAD has not previously been litigated. Claimant's current claim for right CAD involves different operative facts than the claim litigated before Referee Fink in 1975.

SAIF's 1976 acceptance was limited to claimant's March 4, 1975 MI. The acceptance did not include claimant's underlying CAD.

There are no amounts due in this claim against which to assess a penalty. Nor is there resistance to compensation on which to base an attorney fee.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Reply Brief

Claimant's reply brief was due on September 9, 1993, 14 days from the date of mailing of SAIF's respondent's brief. OAR 438-11-020(3). Since the Board did not receive claimant's reply brief until September 13, 1993, the brief was rejected as untimely. Claimant moves for reconsideration of this rejection explaining that the brief was late due to a calendaring error. In support of his motion, claimant relies on the Board's decision in Annie M. Neuberger, 44 Van Natta 1016 (1992). SAIF opposes the motion.

Ordinarily, the Board will not consider a brief that is untimely filed unless a request for an extension is granted. Extensions of time for filing of briefs are allowed only on written request filed no later than the date the brief is due. OAR 438-11-020(3). Briefing extensions will not be allowed unless the Board finds that extraordinary circumstances beyond the control of the party requesting the extension justify the extension. Id. In the Neuberger case relied on by claimant, the Board accepted a claimant's untimely respondent's brief because it was useful to the Board in analyzing a complex case, and the employer did not object to the brief.

Here, claimant did not file a request for a briefing extension within the requisite time period. Furthermore, unlike Neuberger, the opposing party objected to the extension request. In addition, we do not find claimant's counsel's "calendaring error" to constitute an extraordinary circumstance beyond the control of the requesting party. Finally, again unlike the situation in Neuberger, considering claimant's extensive appellant's brief as well as his thorough motion for remand, we do not consider the reply brief to be indispensable in analyzing the issues before us. Accordingly, we adhere to our prior decision and reject claimant's reply brief as untimely. In any event, our consideration of the brief would not change our ultimate disposition of this case.

Remand for Consideration of Director's Order

Claimant has moved the Board to consider a preliminary Director's order issued on April 12, 1994, pursuant to ORS 656.248(13). That order addresses a dispute between SAIF and a medical service provider over payment for oxygen therapy for claimant's current heart condition. The Director's preliminary order includes an adverse credibility finding in regard to the testimony of Ms. Stone, SAIF's claims examiner. Ms. Stone also testified at the hearing in the case presently before the Board. Claimant contends that the Director's adverse credibility finding establishes that Ms. Stone's testimony in the present case is not credible. SAIF opposes claimant's motion.

To the extent that claimant seeks admission of evidence which is not already in the record, his motion is interpreted as a motion to remand to the Referee for the taking of additional evidence. ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). We may remand a case for additional evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). We conclude that the record in this case is not improperly, incompletely or otherwise insufficiently developed without the pending Director's order. Accordingly, we decline claimant's motion to remand this case for consideration of the Director's adverse credibility ruling.

In deciding that remand would not be appropriate, we have considered the following factors. First, during the hearing before the Referee, claimant had the opportunity to fully cross-examine Ms. Stone and to otherwise introduce rebuttal evidence. Furthermore, claimant has not established that the Director's findings and conclusions have any direct bearing on the issues before the Board. The Director concluded that Ms. Stone promised to pay for claimant's oxygen therapy so that SAIF is now estopped from denying payment. This is clearly a collateral matter not directly relevant to the issues raised on review.

Moreover, our disposition of this case would be the same with or without Ms. Stone's testimony. Specifically, we need not rely on Ms. Stone's testimony regarding the meaning of the "801, 995" codes on SAIF's 1976 acceptance. Published industry standards included in the record, along with the testimony of SAIF employee Carol Bachofner, independently establish that SAIF used these codes to refer to MI, CAD and numerous other diseases of the circulatory system. (Ex. 170, Tr. 102-119). Ms. Stone's testimony is otherwise relevant only in determining whether SAIF unreasonably denied claimant's CAD claim or unreasonably failed to provide timely discovery. As discussed below, claimant would not be entitled to penalties and attorney fees even if SAIF's conduct was unreasonable.

Res Judicata

On review, claimant contends that SAIF's denial of treatment for his current heart condition is barred by res judicata. 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). The res judicata doctrine of issue preclusion acts as a bar when the same parties actually litigate an issue of law or fact which is necessary to a valid and final judgment. Id. Under the res judicata 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).

Here, claimant argues that compensability of his CAD was litigated before Referee Fink and found to be compensable, so that SAIF's denial is barred by issue preclusion. Alternatively, claimant contends that SAIF's denial is barred by claim preclusion because the current claim for CAD involves the same operative facts as the cause of action litigated before Referee Fink.

The record does not support claimant's assertion that compensability of his CAD was litigated before Referee Fink and found to be compensable. Although a claim for the CAD was made in 1975 and denied by SAIF, the record indicates that claimant chose not to litigate compensability of the condition before Referee Fink. There is no mention of the CAD in Referee Fink's order. Furthermore, Referee Fink expressly ruled that the "myocardial infarction [claimant] suffered March 4, 1975 is compensable." Finally, rather than setting aside SAIF's denial in its entirety, Referee Fink ordered SAIF to "accept this workman's claim and provide to him the benefits of the Workmen's Compensation Law."

Claimant would have the Board conclude that Referee Fink's reliance on Dr. Griswold's August 1975 opinion is tantamount to a ruling that claimant's CAD is compensable. Dr. Griswold opined that claimant's work activity on March 4, 1975 "aggravated his preexisting cardiac condition and contributed to the development of his acute myocardial infarction." (Ex. 6). However, Referee Fink only discusses Dr. Griswold's opinion in relation to the myocardial infarction, and the Referee's reliance on the opinion must be interpreted in light of the limited scope of his ultimate ruling. Moreover, Dr. Griswold's opinion at most supports a finding that the work activity temporarily aggravated the underlying CAD. Dr. Griswold rendered no opinion as to whether claimant's work activity permanently worsened claimant's CAD.

Accordingly, we conclude that the issue of the compensability of claimant's CAD has not been previously litigated and found compensable. Thus, SAIF's denial of the condition is not barred by issue preclusion. See James M. King, 45 Van Natta 2354 (1993) (denial of CAD not barred by prior Referee order finding MI compensable).

Nor is the denial barred by claim preclusion. A claim is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating, supra. The claim litigated before Referee Fink did not arise from the same operative facts as the current claim for right CAD. Claimant's current condition is the result of a progressive pathological worsening of claimant's CAD which occurred after the 1975 litigation. Claimant's condition has changed, giving rise to a new set of operative facts that could not have been previously litigated. Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560, 563-564 (1989); Drews v. EBI Companies, 310 Or 134, 140 (1990); James M. King, supra. Thus, the claim preclusion doctrine is not applicable in this case. Moreover, assuming the doctrine were applicable, it would bar claimant's claim rather than SAIF's denial.

Scope of Acceptance

We adopt the Referee's order on this issue as supplemented below.

At hearing, claimant argued that SAIF's payment for treatment of claimant's continuing chest symptoms supported a finding that SAIF's acceptance included claimant's underlying CAD. The Referee correctly concluded that payment of medical benefits does not constitute an acceptance of the condition treated. ORS 656.262(9). On review, claimant makes a similar argument regarding SAIF's payment of permanent total disability benefits. SAIF's failure to challenge the permanent disability award and its payment of that disability does not constitute an acceptance of the condition for which the award was made. ORS 656.262(9). Maximino Cardenas, 45 Van Natta 457 (1993), aff'd mem 124 Or App 681 (1993); Dotty C. Fowler, 45 Van Natta 951 (1993).

Penalties and Attorney Fees

We affirm the Referee's conclusion that claimant is not entitled to a penalty and related attorney fee. As discussed above, we have affirmed the Referee's ultimate conclusion that claimant's CAD claim is not compensable. Thus, there are neither amounts due against which to assess a penalty, nor resistance to compensation on which to base an attorney fee. ORS 656.262(10) and 656.382(1).

ORDER

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

Board Member Gunn dissenting.

Because I believe the SAIF Corporation accepted not only claimant's 1975 myocardial infarction but also his underlying coronary artery disease, I would conclude that the latter coronary disease is part of claimant's accepted claim. Therefore, I respectfully dissent.

After my review of the record, I conclude that the medical evidence establishes that claimant's 1975 myocardial infarction was not a separate condition from his underlying coronary artery disease, but was merely a symptom of the underlying disease. By accepting that symptom, i.e., the myocardial infarction, SAIF also accepted the underlying coronary disease that caused the infarction. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988). Accordingly, I would hold that SAIF's "current condition" denial should be set aside as an improper "back-up" denial of the previously accepted coronary artery disease. See Bauman v. SAIF, 295 Or 788, 793-94 (1983).

In the Matter of the Compensation of
ROBERTA L. TORREY, Claimant
WCB Case No. 93-04544
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of Referee Garaventa's order which declined to award an attorney fee under ORS 656.386(1) for claimant's attorney's alleged services in setting aside a "de facto" denial without a hearing. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

The parties agree that the insurer received Dr. Jany's January 28, 1993 chart note on February 8, 1993.

The insurer formally accepted the claim for left fingertip amputation and temporary adjustment disorder (resolved) on July 2, 1993. (Ex. 29).

The parties agree that if a claim for a psychological condition was made in early February 1993, then claimant's attorney was instrumental in obtaining compensation without a hearing and is entitled to an attorney fee under ORS 656.386(1). (Opinion and Order at 2).

The parties further agree that if a claim for a psychological condition was made in early April 1993, then claimant's counsel is not entitled to an attorney fee. Id.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer had not received a claim for a psychological condition, allegedly related to an accepted claim for a partial finger amputation, until the insurer received the treating psychiatrist's chart notes and billings on April 5, 1993. Because the insurer accepted the claim within 90 days, on July 2, 1993, the Referee concluded that claimant's counsel was not entitled to an attorney fee under ORS 656.386(1).

In her appellate briefs, claimant contends that a claim for a psychological condition was first made by Dr. Jany, treating orthopedist, in his January 28, 1993 chart note. Therefore, because the insurer received this chart note on February 8, 1993, claimant contends that a claim was first made in early February, and she is entitled to an attorney fee under ORS 656.386(1). We agree.

A claim is "a written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). A physician's report requesting medical treatment for a specified condition constitutes a claim. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992); William H. Waugh, 45 Van Natta 919 (1993).[1]

On January 28, 1993, during a follow-up examination of claimant's finger amputation, Dr. Jany indicated that claimant "is going to need counseling regarding this loss. I would agree with the occupational therapist, the patient is quite angry and upset about this whole matter, so we will proceed with that also." (Ex. 4). We find that Dr. Jany's chart note constitutes a claim for psychological treatment (counseling) for a specified condition, claimant's reaction to the amputation of her finger.

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[1] Contrary to the insurer's assertion, our opinion in William H. Waugh, supra, did not impose the additional requirement that the requested medical treatment be provided before a doctor's report requesting medical services will constitute a claim. Rather, our opinion merely followed the court's holding in Safeway Stores, Inc. v. Smith, supra. Indeed, the facts underlying the Waugh case are similar to those in the present case. In Waugh, medical treatment was being provided for the accepted condition when the physician requested medical services for a separate, specified condition. We held, consistent with Smith, that the physician's request constituted a claim. That is the case here as well.

The insurer concedes that it received the January 28, 1993 chart note on February 8, 1993. (See Respondent's Brief at 6, 10). Under these circumstances, we conclude that the insurer had notice or knowledge of a claim for a psychological condition on February 8, 1993.

Pursuant to the parties' stipulation, as set forth in the Referee's order, we understand that the insurer concedes that if a claim was made in early February, claimant's counsel was instrumental in obtaining compensation without a hearing and is entitled to an attorney fee under ORS 656.386(1). Accordingly, we turn to a determination of the amount of a reasonable attorney fee in this case.

With respect to obtaining acceptance of the claim for a psychological condition, the record reveals that claimant's counsel requested a hearing in April 1993 and obtained a report from the treating psychiatrist in June 1993. (Ex. 25). The insurer did not accept the claim until July 2, 1993, six days prior to the scheduled July 8, 1993 hearing. Under these circumstances, we find that a reasonable attorney fee for claimant's counsel's services in obtaining compensation without a hearing is $1,000, to be paid by the insurer. In reaching this conclusion, we have considered the factors set forth in OAR 438-15-010(4), particularly the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 27, 1993 is reversed. Claimant's attorney is awarded $1,000 for services in obtaining compensation without a hearing, to be paid by the insurer.

In the Matter of the Compensation of
JOHN W. WANTOWSKI, Claimant
WCB Case Nos. 93-06987, 93-04905 & 93-06986
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Stoel, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Kemper Insurance Company requests review of that portion of Referee Menashe's order that awarded claimant an assessed attorney fee pursuant to ORS 656.386(1), payable by Kemper and Aetna Casualty & Surety Company equally. In its brief, Kemper argues that claimant is not entitled to an assessed attorney fee payable by any of the insurers. On review, the issue is 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.

Cigna disclaimed responsibility for claimant's "new injury" claim for a low back condition. Cigna conceded that claimant's low back condition was compensable, indicated that it would request designation of a paying agent pursuant to ORS 656.307, and suggested that claimant's low back condition was an aggravation of his prior back injury for which either Aetna or Kemper was responsible.

In response to Cigna's request for designation of a paying agent, the Department contacted Aetna and Kemper concerning the compensability of claimant's low back condition. Kemper notified the Department that "our denial should be interpreted as a responsibility as well as a compensability denial. Therefore, we do not believe a paying agent should be designated." Aetna similarly denied both compensability and responsibility. Thereafter, the Department declined to designate a paying agent.

At hearing, Aetna and Kemper agreed that claimant's low back condition is "work-related." Aetna and Kemper clarified that their respective denials were intended only to deny that claimant's aggravation claims were compensable as to them.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee/Hearing Level

The Referee upheld Kemper and Aetna's denials of claimant's aggravation claims for a low back condition, and set aside Cigna's denial of claimant's "new injury" claim for the same condition. Further, finding that claimant had prevailed on the compensability issue, and that Aetna had prevented issuance of a .307 order designating a paying agent, the Referee found Aetna responsible for claimant's assessed attorney fee. On reconsideration, the Referee concluded that both Aetna and Kemper precluded a .307 order from issuing. Therefore, the Referee apportioned claimant's assessed attorney fee award equally between Aetna and Kemper.

On review, relying on John L. Law, 44 Van Natta 1619 (1992), Kemper contends that claimant is not entitled to an assessed attorney fee under ORS 656.386(1) payable by any insurer, because Cigna never denied compensability and both Aetna and Kemper conceded compensability at hearing. Alternately, Kemper requests that the attorney fee be assessed against Aetna and Cigna.

Subsequent to the filing of briefs in this case, the Board disavowed Law and its progeny, to the extent that Law held that a claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) when a "participating" carrier (i.e., a carrier who remained a party to the hearing concerning the responsibility issue) rescinded the compensability portion of its denial prior to hearing. Penny L. Hamrick, 46 Van Natta 14 (1994). Upon reexamination of Multnomah County School District v. Tigner, 113 Or App 405 (1992) (the holding upon which Law was based), we instead concluded that where a carrier who had rescinded its compensability denial prior to hearing participated in the responsibility hearing, a claimant's counsel is entitled to a carrier-paid attorney fee under ORS 656.386(1) payable from that carrier for obtaining compensation for the claimant without a hearing. Hamrick, supra.

In the instant case, it is undisputed that "participating" carriers Aetna and Kemper initially issued "compensability" and "responsibility" denials of claimant's aggravation and medical services claims. Moreover, at hearing, both Aetna and Kemper conceded that claimant's low back condition is "work-related."

Under these circumstances, we find that claimant's attorney was instrumental in obtaining concessions of compensability from Aetna and Kemper. We conclude, therefore, that claimant is entitled to a carrier-paid attorney fee for his counsel's efforts in obtaining the withdrawal of the compensability portions of Aetna and Kemper's denials prior to hearing. Id.

Further, we decline to assess an attorney fee against Cigna. Cigna never denied the compensability of claimant's low back condition. Rather, Cigna only disclaimed responsibility for claimant's "new injury" claim, whereas Aetna and Kemper denied the compensability of, as well as responsibility for, claimant's low back condition.

Finally, we modify that portion of the Referee's order which held that Aetna and Kemper were jointly responsible for a $2,250 carrier-paid attorney fee. Inasmuch as claimant's counsel has been instrumental in securing the rescission of both carriers' compensability denials prior to hearing, we conclude that counsel is entitled to a separate attorney fee for each rescission. See Dale A. Karstetter, 46 Van Natta 147 (1994).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,125 is a reasonable assessed attorney fee for claimant's counsel's services concerning each rescission of the compensability portions of the denials issued by Aetna and Kemper. Therefore, in lieu of the Referee's "joint" award, claimant's attorney is granted two separate $1,125 attorney fee awards, one award payable by Aetna, and one award payable by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the issues, (as represented by the hearing record), the complexity of the issues presented, the risk that claimant's counsel might go uncompensated, and the value of the interest to claimant.

Attorney Fee/Board Level

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 services on Board review. State of Oregon v. Hendersott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated August 3, 1993, as reconsidered September 7, 1993, is modified in part and affirmed in part. In lieu of the Referee's award, for claimant's counsel's efforts in obtaining withdrawal of the compensability portions of Aetna Casualty & Surety Company's compensability denial and Kemper Insurance Company's compensability denial, claimant's attorney is granted two separate attorney fee awards of $1,125, one award payable by Aetna, and one award payable by Kemper. The remainder of the order is affirmed.

In the Matter of the Compensation of
DONNA ANDERSON, Claimant
Own Motion No. 93-0657M
OWN MOTION ORDER
Vick & Gutzler, Claimant Attorneys
Employers Insurance of Wausau, Insurance Carrier

Claimant requests that the Board do the following: (1) order reinstatement of her temporary disability benefits from January 4, 1994 through the date of claim closure; (2) assess penalties against the insurer for its "wrongful termination of time loss benefits;" (3) assess penalties against the insurer for its "wrongful underpayment of time loss benefits;" and (4) review the propriety of an offset made by the insurer for a claimed overpayment of time loss benefits.

For the reasons discussed below, we are unable to order the reinstatement of temporary disability benefits as requested. However, we find claimant entitled to penalties and attorney fees for the insurer's unreasonable claims processing. In addition, the insurer is not entitled to unilaterally offset a claimed overpayment.

FINDINGS OF FACT

On March 26, 1986, claimant compensably injured her low back. Claimant's aggravation rights regarding that injury expired on May 21, 1992.

On October 12, 1993, the Board issued an Own Motion Order authorizing the reopening of claimant's claim to provide temporary total disability benefits beginning June 15, 1993, the date of her hospitalization for surgery. The Board also ordered the insurer to close the claim pursuant to OAR 438-12-055, when claimant was medically stationary.

By letter dated January 25, 1994, claimant's attorney informed the Board that claimant's treating physician had found claimant medically stationary as of January 4, 1994. Claimant's attorney also stated that, although the insurer had not yet closed claimant's claim, it had terminated claimant's temporary disability compensation as of January 4, 1994.

The Board allowed the insurer an opportunity to respond to claimant's request and allowed claimant an opportunity to respond to the insurer's response. The parties' responses have been received by the Board.

With its response to claimant's request, the insurer submitted a copy of a Notice of Closure dated March 8, 1994. In that Notice of Closure, the insurer declared claimant medically stationary as of January 3, 1994 and indicated that temporary disability benefits were paid from June 15, 1993 through January 3, 1994.

By letter dated March 25, 1994, the employer noted that claimant's time loss benefits had been underpaid from July 1, 1993 through January 3, 1994. The employer noted that the weekly rate should have been $302.34. The amount owed for the 26 weeks, 3 days in question was $8,719.78; however, the amount paid was $7,510.68, resulting in an underpayment of $1,209.10. In addition, the employer claimed an offset of $433.39 against this underpayment for "overpayment medical stationary status 9/1/93 - 9/13/93," which left an amount due claimant of $775.71.

By letter dated April 11, 1994, claimant's attorney requested that the Board: (1) assess penalties for the insurer's "wrongful underpayment of time loss benefits;" and (2) review the propriety of the offset made by the insurer for the claimed overpayment of time loss benefits.

The Board allowed the insurer an opportunity to respond to claimant's additional request for relief and allowed claimant an opportunity to respond to the insurer's response. The parties' responses have been received by the Board.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that the insurer cannot unilaterally terminate her temporary disability benefits upon receipt of a medical report indicating that she is medically stationary without first closing her claim. On this basis, claimant requests that the Board: (1) reinstate her temporary disability benefits from January 4, 1994 through claim closure; and (2) assess penalties against the insurer for its "wrongful termination of time loss benefits." In addition, claimant requests that the Board: (1) assess penalties against the insurer for its "wrongful underpayment of time loss benefits;" and (2) review the propriety of an offset made by the insurer for a claimed overpayment of time loss benefits.

Inasmuch as the aggravation rights on claimant's 1986 injury have expired, the Board has exclusive own motion jurisdiction over this claim. See Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988). This exclusive jurisdiction includes the authority to enforce our own motion orders. Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986).

Request for Temporary Disability Benefits Through Claim Closure

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). In contrast, prior to claim closure, claimant may be procedurally entitled to temporary disability benefits.

Here, the insurer issued a Notice of Closure on March 8, 1994, which declared claimant medically stationary as of January 3, 1994 and awarded temporary disability compensation from June 15, 1993 through January 3, 1994, the medically stationary date. Claimant does not argue that her medically stationary date is incorrect or that she was not medically stationary at claim closure. Claimant's substantive entitlement to temporary disability benefits ended on her medically stationary date. However, claimant argues that her temporary disability compensation should continue until claim closure. We interpret this as an argument for procedural entitlement to additional temporary disability.

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

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

impose that overpayment, and reversed the award of temporary disability benefits beyond the medically stationary date. Id. at 654; John L. Desmond, 45 Van Natta 1455 (1993).

Here, the insurer's Notice of Closure declared that claimant became medically stationary on January 3, 1994 and that temporary disability benefits were paid through that date. The Notice of Closure determines claimant's substantive entitlement to temporary disability benefits and indicates that temporary disability benefits have been paid through claimant's medically stationary date. Furthermore, claimant does not argue that either the medically stationary date is incorrect or that the substantive temporary disability compensation award is incorrect.

We are without authority to impose a procedural overpayment by awarding temporary disability benefits beyond the date that claimant is substantively entitled to such benefits, i.e. the medically stationary date. Seiber, supra. Therefore, we deny claimant's request for payment of disability from January 4, 1994 through claim closure.

Penalty for the Insurer's Unreasonable Termination of Time Loss Benefits

The Board authorized the reopening of claimant's claim with payment of temporary total disability to begin on June 15, 1993, the date claimant was hospitalized for surgery. ORS 656.276(1)(a). The Board also ordered the insurer to close the claim pursuant to OAR 438-12-055, when claimant was medically stationary.

In a March 7, 1994 letter, the insurer explained the circumstances of the termination of claimant's temporary disability benefits as follows. The insurer has a contractual agreement with the employer by which the employer pays claimant's medical expenses and time loss benefits and the insurer acts only as the Workers' Compensation benefit administrator. On January 6, 1994, the insurer received a report from claimant's attending physician, Dr. Berkeley, M.D., who advised that claimant was medically stationary as of January 3, 1994. The insurer notified the employer that claimant's condition was medically stationary and, therefore, the employer could stop paying claimant temporary disability benefits. The insurer stated that, to its knowledge, claimant was paid temporary disability benefits through January 3, 1994, the date she was deemed medically stationary.

The insurer further explained that, as of March 7, 1994, it had not submitted the "2066" form because it was waiting for the employer to advise it of the total amounts of temporary disability compensation paid. The insurer went on to state that, pursuant to OAR 438-12-055, the insurer can close an own motion claim when medical reports indicate that claimant is medically stationary. The insurer's statement of the law is correct as far as it goes. In fact, OAR 438-12-055 provides that the claim shall be closed by the insurer when medical reports indicate to the insurer that claimant's condition is medically stationary.

However, contrary to the insurer's assertions, it did not close claimant's claim after receiving medical reports indicating that claimant was medically stationary. Instead, it merely stopped payment of temporary disability as of that date. The insurer did not close claimant's claim until March 8, 1994, when it issued the Notice of Closure. (We note that the "2066" form that the insurer indicated it delayed issuing while awaiting information from the employer is the Notice of Closure form used in closing own motion claims). No matter how the insurer characterizes the situation, claimant's claim was not closed until issuance of the Notice of Closure on March 8, 1994. Until that closure, claimant had an open, accepted claim.

OAR 438-12-035(2) provides that "[t]emporary total disability compensation shall continue to be paid under the relevant statutory provisions and regulations established by the Director for all other claims until termination of such benefits is authorized by the terms of ORS 656.268." ORS 656.268(3) is a claims processing statute that provides grounds for procedurally terminating temporary disability benefits. If the requirements of any of the three subsections of ORS 656.268(3) are met, the insurer may unilaterally terminate claimant's temporary disability compensation. By virtue of OAR 438-12-035(2), ORS 656.268(3) applies to procedural entitlement to temporary disability compensation in own motion claims.

Here, claimant had an open, accepted claim at the time the insurer unilaterally terminated her benefits as of January 4, 1994. Furthermore, there is no evidence that any of the requirements in ORS 656.268(3) were met that would enable the insurer to unilaterally terminate claimant's temporary disability compensation prior to claim closure. In addition, claimant's claim was not closed until March 8, 1994.

We find unreasonable the insurer's failure to pay temporary disability benefits on an open, accepted claim through the date of claim closure, where there was no basis for the insurer to unilaterally terminate the payment of such benefits prior to closure. Lebanon Plywood v. Seiber, 113 Or App at 654; John L. Desmond, supra; Pascual Zaragosa, 45 Van Natta 1221 (1993), aff'd mem 126 Or App 544 (1994). Accordingly, we assess a penalty in the amount of 25 percent of the temporary disability compensation that was due from January 4, 1994 through March 8, 1994. One-half of the penalty shall be payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10).

Penalties for the Insurer's Unreasonable Underpayment of Time Loss Benefits

Claimant requests that the Board assess penalties against the insurer for its "wrongful underpayment of time loss benefits." Penalties may be assessed against an insurer who unreasonably delays or refuses to pay compensation. ORS 656.262(10).

By letter dated March 25, 1994, the employer stated that claimant's time loss benefits had been underpaid by $1,209.10 for the period from July 1, 1993 through January 3, 1994. The insurer explained that this underpayment occurred because claimant's time loss benefits had not been increased in accordance with revised Bulletin 111, issued on May 26, 1993, which outlined the statutory increases in temporary total disability benefits that were effective as of July 1, 1993. Other than stating that this underpayment was an "oversight," the insurer offers no explanation as to the reason for the underpayment.

The insurer's characterization of this underpayment as an "oversight" indicates that the underpayment was not intentional. However, we find that the insurer's failure to abide by revised Bulletin 111 was unreasonable. As noted above, the insurer explained that it has an agreement with the employer whereby the employer pays the medical and time loss benefits and the insurer only acts as the workers' compensation administrator. However, the existence of that arrangement does not create an excuse for delays in payment of compensation to claimant. Revised Bulletin 111 announced statutory increases in temporary total disability benefits which were effective July 1, 1993. Claimant was not paid this increase until about March 25, 1994. This delay in the payment of compensation is unreasonable.

Accordingly, we assess a penalty of 25 percent of $1,209.10, the amount underpaid for the period from July 1, 1993 through January 3, 1994. One-half of the penalty shall be payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10).

Offset

In the same letter that the employer advised claimant that it had underpaid her time loss benefits, it advised her that it was taking an offset of $433.39 against that underpayment for an alleged overpayment of time loss during the period from September 1, 1993 through September 13, 1993. (Letter dated March 25, 1994 from Brenda Treptow). By letter dated May 9, 1994, the insurer stated that the overpayment actually covered the period from September 1, 1993 through September 22, 1993, during which time it contends claimant was medically stationary prior to a subsequent reauthorization for time loss on September 23, 1993, and a final declaration of medically stationary status by her treating physician as of January 3, 1994. Claimant requests that the Board review the propriety of the insurer's offset.

Even assuming that an overpayment was made, an insurer may not unilaterally recoup an overpayment, but must first obtain approval from the Evaluation Division, a referee, or the Board. See Forney v. Western States Plywood, 66 Or App 155 (1983). Here, because claimant's claim is in own motion status, the insurer must first obtain approval from the Board in its own motion authority. In other words, there is no statute which authorizes unilateral action by an insurer to recover an overpayment in this situation. Argonaut Insurance Company v. Mock, 95 Or App 9 (1989); Terrie G. Palumbo, 45 Van Natta 1145 (1993). Accordingly, the insurer is ordered to pay the benefits it improperly offset.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAY B. HAMPTON, JR., Claimant
WCB Case No. 93-08790
CORRECTED ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee McCullough's order that awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for his right forearm/hand, whereas the Order on Reconsideration had awarded none. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because a medical arbiter suggested that claimant intermittently rotate away from use of a chainsaw as an approach to control claimant's right upper extremity symptoms, claimant had established his inability to use his right wrist/hand repetitively. Consequently, pursuant to OAR 436-35-010(6), the Referee awarded claimant 5 percent scheduled permanent disability for his right forearm/hand. In reaching this conclusion, the Referee distinguished our order in Rae L. Holzapfel, 45 Van Natta 1748 (1993), aff'd mem 127 Or App 208 (1994). We disagree with the Referee's reasoning and conclusion.

A worker's inability to repetitively use a scheduled body part must be established by a preponderance of the medical evidence. OAR 436-35-010(6). Only the attending physician and the medical arbiter can rate impairment. ORS 656.245(3)(b)(B); ORS 656.268(7); See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994).

In Rae L. Holzapfel, supra, a referee awarded the claimant 14 percent scheduled permanent disability for each forearm (wrist). The referee relied on the opinions of two physicians who had recommended that the claimant avoid repetitive strenuous work with her hands to prevent increased symptoms. We reversed the referee's permanent disability award, because the physicians had not stated that the claimant was unable to use her hands repetitively, nor had they made any findings from which we could conclude that the claimant was unable to do so. Id. at 1749. We also held that the physicians' recommendations regarding avoiding repetitive activities were insufficient to establish a permanent and chronic condition of the wrists under OAR 436-35-010(6). Id.

In Kathleen L. Hofrichter, 45 Van Natta 2368 (1993), we reached a similar conclusion. There, the claimant contended 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 disagreed, because there was no medical evidence that the claimant was unable to use her low back repetitively. The claimant's treating physician had recommended that the claimant avoid repetitive motions of her back, and work that required forward bending, to prevent increased symptoms. Citing Rae L. Holzapfel, supra, we concluded that that evidence was insufficient to establish a permanent and chronic impairment of the back. Kathleen L. Hofrichter, supra, 45 Van Natta at 2369. For the following reasons, we find this case indistinguishable from Holzapfel and Hofrichter.

Claimant relies on the medical opinions of Dr. Warran, attending physician, and Dr. Coletti, medical arbiter. In his closing examination report, Dr. Warran found that claimant had full range of motion of the wrists and fingers bilaterally, as well as normal grip and sensation to touch on the fingers. (Ex. 1-6). Warran then concluded that, although claimant still had mild tenderness and pain at the base of the palms, he was "medically stationary with essentially no permanent partial disability." (Id.).[1]

[1] Claimant argues that, because Dr. Warran's closing examination report noted that claimant still had mild tenderness and pain at the base of the palms, and that claimant "essentially" had no permanent disability, Dr. Warran necessarily found that claimant had "some" permanent disability. That argument is not well-taken. See OAR 436-35-010(6).

In his medical arbiter's report, Dr. Coletti recorded claimant's history and current symptoms, including right volar wrist pain while operating a chainsaw and right wrist weakness and an occasional popping sensation with use of the right wrist. (Ex. 14-2). Claimant reported that his symptoms were relieved by moving to a yarder, although he still experienced occasional right wrist weakness and discomfort. (Id.)

On examination, Dr. Coletti noted no atrophy or weakness of the intrinsic musculature of claimant's upper extremities. (Id. at 3). He reported that claimant's upper extremity strength, including grip, was normal, and that there was no evidence of abnormal alignment, deviation or length of upper extremities, or focal weakness, dystrophy, effusion, or carpal instability or tenderness. (Id.)

Based on these findings, Dr. Coletti concluded that claimant "is able to repetitively use the upper extremities[.]" (Id.) Coletti then noted that it was "possible that [claimant] may experience some pain with repetitive heavy use of the right upper extremity * * *." (Id.) Therefore, Coletti concluded that:

> "it would seem that rotation of tasks every two to three hours, from the standpoint of chain saw use, might be a reasonable approach to symptom management. There is no objective evidence of any condition "operating at this point today based on this examination, and the basis for my comment with regard to limitation of use is based primarily on the history provided me today." (Id.)

Here, as in Holzapfel and Hofrichter, there is no medical evidence that claimant was unable to use a scheduled body part repetitively. Dr. Warran generally concluded that claimant essentially had no permanent partial disability, whereas Dr. Coletti specifically concluded that claimant is able to use his right upper extremity repetitively. Neither physician has made findings from which we can conclude that claimant is unable to use his right forearm/hand repetitively.[2] In light of the possibility that claimant might experience right arm symptoms with repetitive heavy equipment use, Dr. Coletti suggested that claimant avoid continuous repetitive work with his right upper extremity as a means of symptom control. We find that suggestion insufficient to establish a permanent and chronic impairment of claimant's right forearm/hand. Rae L. Holzapfel, supra; Kathleen L. Hofrichter, supra; see OAR 436-35-010(6).

ORDER

The Referee's order dated November 16, 1993 is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety.

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[2] Claimant argues that Dr. Coletti's conclusion that there was no objective evidence of permanent impairment does not follow from his findings. We disagree.

June 14, 1994 Cite as 46 Van Natta 1165 (1994)

In the Matter of the Compensation of
JOHN R. JOHANSON, Claimant
WCB Case No. 93-10812
ORDER VACATING DISMISSAL ORDER
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On May 26, 1994, we withdrew our May 17, 1994 order which had dismissed the self-insured employer's request for Board review. In dismissing the employer's appeal, we had presumed that the employer's request (which was not mailed by certified mail and was actually received by the Board more than 30 days from the Referee's March 18, 1994 order) was untimely. See OAR 438-05-046(1)(b). However, noting that this presumption was rebuttable, we advised the employer that we were willing to reconsider our decision provided that the employer could establish that its request for review was timely mailed to the Board.

As noted above, on May 26, 1994, we withdrew our dismissal order to consider several affidavits from the employer's legal counsel and counsel's employees which attest that the employer's original request for review of the Referee's March 18, 1994 order was mailed to the Board on April 1, 1994. We also granted the other participants an opportunity to respond. Having received claimant's response, we proceed with our reconsideration.

According to affidavits from the employer's counsel and counsel's employees, the employer's counsel signed an original request for Board review on April 1, 1994 which was placed in a stamped envelope addressed to the Board's Salem office and delivered to the Medford, Oregon post office that same day. In response, claimant's counsel neither contests the representations contained in the employer's affidavits nor contradicts the employer's counsel's certification that copies of the request were mailed to all parties to the proceeding.

Subsequent to our May 26, 1994 abatement order, we issued an Order of Dismissal in Leola M. Johnson, 46 Van Natta 1078 (1994). In Johnson, we found that a request for Board review had erroneously been acknowledged as an appeal in that case. We further noted that the request for review had actually been filed by the self-insured employer in this case. That request was received by the Board's Salem office on April 4, 1994.

The Referee's order issued March 18, 1994. Inasmuch as April 4, 1994 is within 30 days of the Referee's order, we conclude that the employer's request for Board review was timely. ORS 656.289(3); ORS 656.295(2); OAR 438-05-046(1)(a). Consequently, we retain authority to consider this appeal.

Accordingly, on reconsideration, we withdraw our May 17, 1994 dismissal order. Since no oral proceedings were held in this case, there will not be a hearing transcript. Therefore, the following briefing schedule shall be implemented.

The employer's appellant's brief shall be due 21 days from the date of this order. Claimant's respondent's brief shall be due 21 days from the date of mailing of the employer's brief. The employer's reply brief shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSINA D. CAMPOS, Claimant
WCB Case No. 93-08435
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Podnar's order that: (1) affirmed the Order on Reconsideration award of 5 percent (6.75 degrees) scheduled permanent disability for the loss of use or function of the right foot; (2) awarded an assessed attorney fee for prevailing against SAIF's appeal of the scheduled award; and (3) increased claimant's unscheduled permanent disability award from 19 percent (60.8 degrees), as awarded by Order on Reconsideration, to 25 percent (80 degrees). On review, the issues are extent of permanent disability, scheduled and unscheduled, and attorney fees. We affirm.

FINDINGS OF FACT

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

We do not find that claimant is currently restricted to light/sedentary work. Instead, we find that claimant is restricted to light work, with no lifting or carrying over 20 pounds.

CONCLUSIONS OF LAW AND OPINION

Scheduled Disability

Both the Department's Appellate Review Unit and the Referee found that claimant has a permanent, partial loss of plantar sensation and awarded her 5 percent scheduled permanent disability for the loss of right foot function. The finding of plantar sensation loss was based on the report of Dr. Englander, neurologist and medical arbiter. Dr. Englander reported decreased sensation circumferentially along claimant's entire right leg, and commented:

> "The reduction [in sensation] that [claimant] has circumferentially in her right leg to pinprick and touch also includes the plantar surface of the foot. This is not in an anatomic distribution. It is partial loss of sensation." (Ex. 14-3, emphasis added).

On review, SAIF argues that Dr. Englander's comment effectively invalidates the finding of plantar sensation loss. We disagree. We interpret Dr. Englander's comment more narrowly. He viewed the sensation loss circumferentially along the entire right leg and the plantar surface as not following an anatomic distribution. However, rather than invalidating the entire loss of sensation, Dr. Englander unambiguously finds a "partial loss of sensation." That finding is consistent with claimant's testimony at hearing (Tr. 10), and is not controverted by other medical evidence in the record. Therefore, we agree with the Referee that claimant has sustained a partial loss of plantar sensation. Accordingly, claimant is entitled to 5 percent scheduled permanent disability for loss of right foot function. See former OAR 436-35-200(1).

Inasmuch as we, like the Referee, are affirming the Order on Reconsideration award of scheduled disability, we affirm the Referee's assessed attorney fee award for prevailing against SAIF's appeal of that award.

Unscheduled Disability

We adopt the Referee's conclusions and opinion regarding this issue, with the following exception.

Regarding the adaptability factor, the Referee found that claimant's maximum residual functional capacity (RFC) is in the light-sedentary range. Based on that finding, the Referee assigned a value of 2 for the adaptability factor. We disagree.

It is undisputed that claimant became medically stationary on January 27, 1993. On that date, Dr. Maloney, claimant's attending physician, wrote:

> "[Claimant] is considered capable of initial part-time [sic] with steady progression to full-time sedentary to light work. She is able to lift up to 10-20 pounds, carry up to 20 pounds. She is able to lift and carry at 15 pounds on an occasional basis." (Ex. 11).

Dr. Englander, the medical arbiter, wrote that claimant should be restricted from regular and repetitive use of her low back, but attributed the restriction to general obesity and deconditioning, rather than the accepted injury. (Ex. 14-3). He concluded that "there is no limitation on [claimant's] residual functional capacity as it relates to the accepted injury though her capacity is limited by unrelated factors." (Ex. 14-4).

Dr. Maloney has been treating claimant since October 1992, whereas Dr. Englander has examined claimant only once. We find, therefore, that Dr. Maloney has had a better opportunity to evaluate claimant's RFC as a result of the accepted injury. Although Drs. Newby, Burr and Brooks have also rendered opinions concerning claimant's RFC, those opinions were rendered several months before claimant attained medically stationary status and, therefore, are less persuasive.

"Light work" requires "[l]ifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds." Former OAR 436-35-270(3)(g)(B). Although Dr. Maloney states that claimant is restricted to sedentary-light work, we find that the actual lifting and carrying restrictions (up to 20 pounds) place claimant in the light work category. In this regard, we find that Dr. Maloney's restriction for claimant to lift or carry 15 pounds on an occasional basis does not preclude claimant from lifting or carrying 10 pounds on a frequent basis. Accordingly, we conclude that claimant's maximum RFC is in the light category.

Both parties concede that claimant's prior strength demand was in the medium category. Therefore, we assign a value of 3 for the adaptability factor. See former OAR 436-35-310(3).

We now compute claimant's unscheduled award. The sum of claimant's age (1) and education (5) values is 6. That sum is multiplied by the adaptability value (3) for a product of 18. That product is added to the impairment value (13) for a total unscheduled award of 31 percent. However, inasmuch as claimant did not appeal the Referee's 25 percent unscheduled award, we affirm the Referee's award.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review regarding the extent of permanent disability issues. 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 issues is $900, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 1, 1993 is affirmed. Claimant's attorney is awarded $900 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MARK A. ROBERTS, Claimant
WCB Case No. 93-07838
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband and Gunn.

The insurer requests review of Referee Schultz's order that increased claimant's scheduled permanent disability award for loss of use or function of the left foot (ankle) from 8 percent (10.8 degrees), as granted by an Order on Reconsideration, to 13 percent (17.55 degrees). On review, the issue is scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for ultimate finding of fact (number 1) that claimant has a permanent chronic condition in his left ankle that limits repetitive use of the ankle.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving the extent of disability resulting from his compensable injury. ORS 656.266. 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).

The Referee found that claimant was entitled to a chronic condition award, in part because he found that claimant's testimony regarding his limitations was credible. Lay testimony is insufficient to establish "impairment" under the standards. OAR 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).

The Referee also relied on the opinions of Drs. Tennant and Stanford for the chronic condition impairment award. Although we agree with the Referee and claimant that it is not necessary that either doctor use the words "chronic condition," we conclude that claimant has failed to prove he is entitled to a chronic condition impairment award. Neither Dr. Tennant nor Dr. Stanford stated that claimant is unable to repetitively use his left ankle, nor did either of them make findings from which we can conclude that claimant is unable to do so. See Rae L Holzapfel, 45 Van Natta 1748 (1993); Donald E. Lowry, supra.

Dr. Tennant, an orthopedist, stated that claimant is able to cope at work because he is performing less strenuous activity. (Ex. 11). Dr. Tennant noted that claimant's leisure activities have been "hampered" by the injury and that he has pain when he dorsoflexes his ankle. Nevertheless, Dr. Tennant reported that claimant is able to participate in paint-ball tournaments every other weekend where he plays for eight hours a day. (Id.) Dr. Tennant further stated that claimant wears an air cast when playing paint-ball and he develops some swelling post-play. (Id.)

Dr. Stanford, the medical arbiter, concluded that claimant could not do heavy work. He stated that claimant's symptoms result in "episodic pain, which could be dangerous in a heavy work situation." (Ex. 14). Dr. Stanford's recommendation that claimant avoid heavy work does not mean that claimant has lost (or partially lost) his ability to use his ankle repetitively. See David A. Kamp, 46 Van Natta 389, 390 (1994) (work limitations were imposed to avoid likelihood of reinjury; no other medical evidence established that claimant had partially lost his ability to use his neck and right shoulder repetitively); Kathleen L. Hofrichter, 45 Van Natta 2368, 2369 (1993) (physician's recommendation that claimant avoid certain motions at work in order to prevent an increase in symptoms was insufficient to establish permanent and chronic impairment of the back); Rae L. Holzapfel, supra (physicians' recommendation that 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). In fact, Dr. Stanford stated that claimant "walks normally without a limp or a list and he can do a full squat and rise. He can walk on his heels and his toes without difficulty." (Ex. 14).

In light of the opinions expressed by Drs. Tennant and Stanford, we are not persuaded that claimant is unable to repetitively use his left ankle due to a chronic and permanent medical condition. OAR 436-35-010(6); Donald E. Lowry, supra. Accordingly, we reverse the Referee's order which increased claimant's scheduled permanent disability from 8 percent to 13 percent. The Order on Reconsideration award of 8 percent is reinstated and affirmed.

ORDER

The Referee's order dated October 6, 1993 is reversed. The Order on Reconsideration award of 8 percent (10.8 degrees) for loss of use or function of the left foot (ankle) is affirmed.

Board Member Gunn dissenting.

Because I believe the medical evidence is sufficient to support the chronic impairment award, I would affirm the Referee's order that increased claimant's scheduled permanent disability award for loss of use or function of the left ankle. Therefore, I respectfully dissent.

After my review of the record, I conclude that Dr. Tennant made findings from which we can conclude that claimant has a chronic condition limiting repetitive use of his left ankle. See Donald E. Lowry, 45 Van Natta 1452 (1993). Dr. Tennant, claimant's treating orthopedist, reported that claimant's daily activities are troublesome in that when he dorsoflexes his ankle he has pain. (Ex. 11). Dr. Tennant noted that claimant wears an air cast when he engages in sports and he stated that claimant's leisure activities have been hampered by his injury. Although claimant is medically stationary, Dr. Tennant concluded that he is still suffering from some pain and limited motion secondary to the injury he sustained. (Id.)

On this record, I would hold that Dr. Tennant's report, combined with the fact that claimant can only participate in recreational activities with an air cast, supports the conclusion that claimant has a chronic condition limiting repetitive use of his left ankle.

In the Matter of the Compensation of
KATHY A. SCHALK, Claimant
WCB Case No. 91-18475
ORDER ON RECONSIDERATION (REMANDING)
Doblie & Associates, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 26, 1994 Order on Review (Remanding) that vacated the Referee's dismissal order, reinstated claimant's hearing request, and remanded for hearing. Contending that we have misinterpreted its prior position and penalized it for its previous conduct, SAIF asks that we modify our decision to permit the parties an opportunity to present additional evidence on remand regarding claimant's justification for allegedly delaying the hearing. For the following reasons, we adhere to our prior conclusion.

Claimant previously sought Board review, arguing that the record had not been sufficiently developed for the Board to determine whether her conduct had caused an unjustified delay in the hearing. In our May 26, 1994 order, we concluded that because claimant's conduct resulted in a "delay" in the hearing of only 8 days, the Referee was not authorized to dismiss claimant's request for hearing under OAR 438-06-071(1) (referee may dismiss proceeding if conduct results in an unjustified delay of more than 60 days). Consequently, we vacated the Referee's dismissal order and remanded for a hearing regarding claimant's hearing request from SAIF's denial.

On reconsideration, SAIF contends that, although it argued in support of the Referee's order in its brief, it did not intend to waive the original basis for its motion to dismiss, which was that claimant had misrepresented her reason for requesting a postponement of the hearing. SAIF argues that it was entitled to argue in the alternative "without fear of waiving the basis for its original motion to dismiss." (Motion for Reconsideration at 2).

We agree with SAIF that it was entitled to make alternative arguments. We conclude, however, that SAIF waived its argument that postponement of the March 24, 1992 hearing was at issue. In SAIF's respondent's brief, it stated "Even if postponement of the March 24, 1992 hearing were at issue, which it is not, claimant's assertions are untrue." (Respondent's brief at 5). SAIF also stated: "Since postponement of the March 24, 1992 hearing is not at issue, the facts surrounding the postponement are not material. Claimant's evidence on the issue of misrepresentation, therefore, is immaterial." (Respondent's brief at 5). Finally, SAIF asserted in its brief that "Claimant is not entitled to, nor has she demonstrated any need for, additional proceedings on the issue of dismissal." (Respondent's brief at 8).

On reconsideration, SAIF asks the Board to remand for the taking of evidence on the issue of whether claimant's failure to appear at the March 1992 hearing resulted in an unjustified delay in the hearing of more than 60 days. That is precisely the relief claimant previously requested. However, we adhere to our original decision that a hearing as to whether the delay was "unjustified" is not necessary. As a result of SAIF's prior concession that postponement of the March 24, 1992 hearing was not at issue, the beginning date to calculate a "delay" in the proceedings was July 31, 1992. Claimant complied with SAIF's motion for discovery on August 8, 1992. Therefore, the "delay" was only 8 days.

In our previous order, we also noted that SAIF had not objected when claimant's attorney requested a postponement on July 31, 1992. SAIF argues that, at that time, it did not have evidence establishing that claimant had misrepresented her admission to Dammasch, and our order penalizes SAIF for accommodating claimant's counsel's request for a postponement on July 31, 1992.

We do not agree that our order "penalizes" SAIF. Our disposition of this case was based primarily on the fact that SAIF no longer argued about the propriety of the postponement of the March 24, 1992 hearing. Moreover, the postponement of the July 31, 1992 hearing was also uncontested. In any event, even if it was, the reason for the postponement was unrelated to claimant's alleged delay, but rather a conflict in claimant's counsel's schedule. Thus, the July 31, 1992 postponement was important mainly as a beginning date to calculate a "delay" in the hearing.

We withdraw our May 26, 1994 order. On reconsideration, we continue to adhere to the reasoning and conclusions reached in our original order. Accordingly, on reconsideration, as supplemented herein, we republish our May 26, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

The Stone court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that OAR 436-60-030(2) was inconsistent with ORS 656.212, in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the Stone court reasoned that an injured worker's 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. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Because the Stone court remanded the case to the Board to determine whether the claimant's partial disability caused a proportionate loss of earning power at any kind of work, the court did not decide the applicability of Safeway Stores v. Owsley, supra, or address the claimant's contention that Owsley should be overruled. Stone v. Whittier Wood Products, supra, at 124 Or App 124 n.5. However, the court's decision in Stone certainly casts considerable doubt on the continuing vitality of its earlier decision in Owsley. See Libby v. Southern Pac. Co., 109 Or 449, 459 (1923)(where former decisions are apparently in conflict, the court is bound by the latter utterance); Spencer House Moving Company, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993).

Here, other than evidence confirming that claimant's at-injury wage was not affected by his return to modified work in a sedentary position, there is essentially no documentary or testimonial evidence in the record regarding claimant's "earning power at any kind of work." In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work.

Because this record was developed prior to the Stone court's interpretation of ORS 656.212 and its attention to diminished earning power at any kind of work in calculating TPD, the parties did not have an opportunity to present evidence or argument on this crucial issue. Therefore, we find that there is a compelling reason to remand for the submission of additional evidence solely concerning claimant's loss of earning power at any kind of work. See ORS 656.295(5); Lori A. Auterson, 46 Van Natta 262 (1994); Troy Shoopman, 46 Van Natta 21 (1994). At this "remand" proceeding, the parties are also requested to address the effect, if any, the Director's temporary amendments to OAR 436-60-003 and 436-60-030 have on this issue. See WCD Admin Order 94-050.

We acknowledge that claimant has also requested review of the Referee's decision declining to award interim compensation. Since the interim compensation issue rises from a period prior to claimant's departure from work, it is questionable whether the court's decision in Stone will have any effect on this issue. However, since we are already remanding the case for reconsideration of the TPD issue, we find it appropriate to include the interim compensation issue for further consideration. At the remand proceedings, the parties may address the effect, if any, the Stone decision and the previously mentioned administrative rules have on the interim compensation issue.

Accordingly, we vacate the Referee's order dated August 27, 1993. This matter is remanded to Referee Davis for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice, although we would recommend that evidence concerning claimant's employment history (including past/current wages) be presented. See Shoopman, supra at 22 n.2; see also WCD Admin. Order 94-050.[1] Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated August 27, 1993 is vacated. This matter is remanded to Referee Davis for further proceedings consistent with this order.

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[1] If the parties wish to address on remand to the Referee the effect, if any, the Owsley decision has on this dispute in light of the Stone decision, they may do so.

Claimant contends that the insurer's denial was unreasonable in light of Dr. Melson's report relating claimant's condition to his work. However, at the time it issued its denial, the insurer also had a report from Dr. Kho which indicated that claimant's condition was not work-related. In light of Dr Kho's report, we do not find the insurer's denial unreasonable. At any rate, inasmuch as we agree with the Referee that claimant's has not established compensability of his claim, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee as a result of that condition. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated July 16, 1993 is affirmed.

June 20, 1994 Cite as 46 Van Natta 1201 (1994)

In the Matter of the Compensation of
STEPHEN M. SNYDER, Claimant
WCB Case No. 93-02957
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Referee Davis' order that: (1) declined to award interim compensation; and (2) declined to award temporary disability compensation. On review, the issues are interim compensation and temporary disability. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation After March 30, 1993

There is no dispute that claimant was hired as a part-time employee and was compensably injured on December 2, 1992. On December 4, 1992, claimant sought medical treatment and was released to perform "sit down" work. Claimant accepted a modified work offer made by the employer when claimant filed his workers' compensation claim on December 8, 1992. This modified work consisted of sitting in the employer's "radio room" and monitoring local radio stations to ensure that advertisers' commercials were being broadcast. (Tr. 7, 58-59). This job is one that is regularly performed by the employer's firm. Claimant's wages were not affected by the change in work assignment. Due to personal reasons unrelated to the work injury, claimant did not begin the modified job until January 14, 1993. On March 30, 1993, claimant was terminated for reasons unrelated to the work injury.

Citing Safeway Stores v. Owsley, 91 Or App 475 (1988), the Referee reasoned that claimant was entitled only to the amount of temporary disability compensation that he would have received if his employment had not been terminated. Because the modified work paid as much as claimant earned prior to his injury, the Referee concluded that that amount was zero.

Subsequent to the Referee's decision, the court issued Stone v. Whittier Wood Products, 124 Or App 117 (1993), in which it reversed a Board order which had found that the claimant was not entitled to temporary disability because she had been discharged from her modified job for reasons unrelated to her compensable injury (absenteeism and violation of a drug/alcohol policy). Computing the claimant's temporary partial disability (TPD) under OAR 436-60-030(2) at zero, the carrier in Stone did not reinstate temporary disability benefits after her discharge.

In the Matter of the Compensation of
STEVEN V. SKIDGEL, Claimant
WCB Case No. 93-03273
ORDER ON REVIEW
Davis, Gilstrap, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Brown's order that: (1) upheld the insurer's denial of his occupational disease claim for left carpal tunnel syndrome; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant had failed to establish that his work activities were the major contributing cause of his left carpal tunnel syndrome. We agree.

Claimant has the burden of proving, by medical evidence supported by objective findings, that his work exposure, including any series of traumatic events or occurrences which require medical services or result in disability, was the major contributing cause of his left carpal tunnel syndrome. ORS 656.802(1) and (2).

Dr. Heller, an attending chiropractor, opined that claimant's left carpal tunnel syndrome was caused by his work exposure. Heller based his opinion on the time the symptoms started, the history of excessive work, and the sudden increase in heavy physical labor. Dr. Melson, an attending neurologist, also opined that claimant's work activities were the cause of his carpal tunnel symptoms based on the heavy lifting at work and the timing of the onset of the symptoms.

Dr. Kho, examining physician, opined that the major contributing cause of claimant's left carpal tunnel syndrome was his off-work guitar playing. Dr. Kho noted that claimant was right-handed, however the carpal tunnel symptoms were on the left non-dominant side. While Dr. Kho agreed that the work activities may have triggered some of claimant's symptoms, he opined that claimant's guitar playing (approximately two hours per day) involved a left-handed forced flexor movement of the fingers which contributed to the development of a chronic flexor tendinitis resulting in impingement of the median nerve.

Dr. Jewell, who performed a records review, noted that claimant's work activities were varied, but did not involve prolonged flexion of the fingers and wrists. Consequently, Dr. Jewell could not say that claimant's work activities were the major cause of his carpal tunnel syndrome. Dr. Jewell agreed with Dr. Kho that guitar playing did involve flexion of the wrists and fingers with intense repetition which could be considered a major contributing factor to claimant's condition.

While Drs. Keller and Melson relate claimant's symptoms to the work exposure, they do not explain how the occurrence of claimant's condition (left carpal tunnel syndrome) relates to the work exposure. By contrast, Dr. Kho explained that claimant's guitar playing activities contributed to the development of a chronic flexor tendinitis resulting in impingement of the median nerve causing the carpal tunnel symptoms. On this record, we are not persuaded by the opinions of Dr. Keller and Dr. Melson, particularly in light of the well-reasoned opinion from Dr. Kho. See Somers v. SAIF, 77 Or App 259 (1986). Consequently, claimant has not established that his work activities were the major contributing cause of his left carpal tunnel syndrome.

Penalties

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

ORS 656.262(10)(a) provides that the Director shall have exclusive jurisdiction over proceedings regarding solely the assessment of a penalty under that subsection. However, in the present case, in addition to his request for a penalty under ORS 656.262(10), claimant also alleged entitlement to an attorney fee under ORS 656.386(1) for his counsel's efforts in obtaining compensation when a hearing was not held.

Inasmuch as the attorney fee request under ORS 656.386(1) constitutes a "question concerning a claim," the Hearings Division was the proper forum to entertain such a request. ORS 656.283(1). Since that attorney fee request was combined with claimant's request for a penalty under ORS 656.262(10), we hold that the Referee was authorized to consider both the penalty and attorney fee issues.

In other words, since claimant's hearing request did not solely involve the assessment of a penalty within the meaning of ORS 656.262(10), exclusive jurisdiction over this matter rests with the Board, not the Director. See ORS 656.704; 656.283.

Penalties and Attorney Fee

Reviewing for substantial evidence under ORS 656.327(2), the Referee limited the record to the 50 exhibits certified by the Director, and to the arguments advanced by the parties' counsels. At the hearing, the insurer requested that, if the Referee concluded that the Hearings Division had jurisdiction to address the penalty and attorney fee issues, the record remain open for additional testimony and exhibits concerning the reasonableness of the insurer's claims processing. (Tr. 15, 16). The Referee, however, did not admit additional evidence.

We may remand to the Referee if we determine that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, the Referee concluded that the Hearings Division lacked authority to consider the penalty and attorney fee and that the record could not extend to evidence beyond that considered by the Director. As explained above, we have held that the Hearings Division does have jurisdiction over this dispute. Under these circumstances, we conclude that the record is incompletely developed and that there is a compelling reason to remand. ORS 656.295(5).

Accordingly, we remand to the Presiding Referee for assignment to a Referee for further proceedings consistent with this order. The assigned Referee may proceed in any manner that will achieve substantial justice. ORS 656.283(7). At the further proceedings, the parties may present additional evidence concerning the penalty and attorney fee issues.[1] The assigned Referee shall then issue a final appealable order.

ORDER

The Referee's order dated April 5, 1993 is vacated. This matter is remanded to the Presiding Referee for further proceedings consistent with this order.

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[1] Concerning claimant's entitlement to an attorney fee award under ORS 656.386(1) for services rendered in obtaining the Director's order under ORS 656.327(2) finding the recumbent cycle to be appropriate medical treatment, the parties may wish to address on remand to the assigned Referee the effect, if any, the Board's holding in Sherry Y. Drobney, 46 Van Natta 964 (1994), has on this issue.

In the Matter of the Compensation of
JAMES V. JOHNSTON, Claimant
WCB Case No. 92-16193
ORDER ON REVIEW (REMANDING)
Susan D. Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Wood, Tatum, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of that portion of Referee Barber's order which dismissed claimant's hearing request seeking penalties under ORS 656.262(10) or attorney fees under ORS 656.386(1) regarding a medical service dispute which had resulted in a Director's order under ORS 656.327(2) finding a disputed medical service to be appropriate. On review, the issues are jurisdiction, penalties, and attorney fees. We remand.

FINDINGS OF FACT

On August 31, 1992, Dr. Kimberley, claimant's treating physician, prescribed a recumbent cycle for lumbar strengthening and aerobic exercise. (Ex. 31). On September 10, 1992, Dr. Kimberley wrote to the insurer explaining why claimant required the recumbent cycle. (Ex. 34). On September 25, 1992, the insurer wrote to Dr. Kimberley with specific questions concerning claimant's need for the cycle. Dr. Kimberley responded on September 29, 1992.

On October 8, 1992, the insurer requested Director's review of the requested recumbent cycle. On November 18, 1992, Dr. DeMent, medical reviewer, concurred with Dr. Kimberley's opinion concerning claimant's need for the recumbent cycle. The Director's order finding the recumbent cycle appropriate issued December 1, 1992.

In addition to the appropriateness of a recumbent cycle and pulse monitor, the Director's order also addressed whether Dr. Kimberley had violated certain medical service rules in prescribing other treatment to claimant. Finding that Dr. Kimberley had violated OAR 436-10-040(3)(a), the Director forwarded a copy of the decision to the Sanctions Section of DCBS for further action.

Dr. Kimberley requested a hearing regarding the Director's order. Claimant also requested a hearing, seeking penalties under ORS 656.262(10) for the insurer's alleged unreasonable refusal to provide medical services (the recumbent cycle), and attorney fees under ORS 656.386(1). Prior to hearing, the insurer's counsel announced that Dr. Kimberley's objections to the Director's order had been resolved and that such issues were being withdrawn from consideration.

Concerning the remaining penalty and attorney fee issues, the insurer requested that the record remain open for additional testimony and exhibits concerning the reasonableness of the insurer's claims processing. (Tr. 15, 16). The Referee took no testimony and accepted only those exhibits that were before the Director at the time the Proposed and Final Order was issued.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

At the beginning of the hearing, the insurer stated that the recumbent cycle prescribed by claimant's treating physician, Dr. Kimberley, had been furnished to claimant. Additionally, claimant stated that he was not pursuing the issue concerning the appropriateness of a pulse monitor. Further, any issue concerning Dr. Kimberley's violation of certain medical service rules had been resolved by the parties, and the issue was withdrawn from consideration by the Referee. (Tr. 2).

Accordingly, the only issues litigated at hearing were claimant's entitlement to penalties and attorney fees. (Tr. 2, 3). Reasoning that those issues arose from the Director's order, the Referee concluded that the Hearings Division had no jurisdiction to consider them. Alternatively, in the absence of another issue, the Referee determined that the Hearings Division was without authority to consider the penalty and attorney fee issues under ORS 656.262(10(a). We disagree.

In the Matter of the Compensation of
DEBRA A. JOHNSTON, Claimant
WCB Case No. 93-07023
ORDER ON REVIEW
Max Rae, Claimant Attorney
Gary G. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Howell's order that declined to award an attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees.

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

Subsequent to the Referee's order, the Court of Appeals issued its decision in Gamble v. Nelson International, 124 Or App 90 (1993). There, the court held that the claimant was not entitled to an attorney fee under ORS 656.386(1) when the carrier withdrew its responsibility disclaimer before hearing. Reasoning that the disclaimer served only to notify the claimant that his claim may have been compensable against another carrier, the court concluded that the disclaimer was not a denial. Id. at 94. Additionally, the court noted that the responsibility disclaimer did not create an issue concerning the compensability of the claim. Id. Consequently, the court determined that the disclaimer did not provide a basis for an attorney fee award under ORS 656.386(1).

Gamble controls this case, and supports the Referee's decision to decline to assess an attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated September 30, 1993 is affirmed.

Board Member Hall, specially concurring.

I am compelled to accept the result in this case by Gamble v. Nelson International, 124 Or App 90 (1993). In that case, the court held that a claimant is not entitled to an attorney fee under ORS 656.386(1) when the carrier withdraws a "responsibility" disclaimer before hearing.

In Gwen A. Jackson, 46 Van Natta 822 (1994) (order on reconsideration), we recently said that, to be entitled to an attorney fee under ORS 656.386(1), "compensation," but not necessarily "compensability", must be at risk. Jackson was based on an analysis of Shoulders v. SAIF, 300 Or 606 (1986) and Short v. SAIF, 305 Or 541 (1988), as well as ORS 656.386(1).

The Board has also recently issued an order in David Rowe, 46 Van Natta 1150 (1994), in which we awarded an attorney fee pursuant to ORS 656.386(1). There, the carrier issued a document labeled disclaimer of responsibility and claim denial. (See discussion of this distinction in Gamble, supra.)

Although the subject document in the instant case disclaimed responsibility (Ex. 6), I believe that claimant's compensation remained at risk until the insurer withdrew that document. The document states that "compensability" of the claim remained under investigation. The carrier had not accepted or conceded compensability and had not requested a paying agent pursuant to ORS 656.307. (See Ex. 6). Furthermore, the insurer could have contested the compensability of this claim at hearing. See Taylor v. Masonry Builders, Inc., 127 Or App 230 (1994).

Therefore, until the insurer withdrew its "disclaimer" and accepted this claim, claimant's compensation was at risk; indeed, compensability was at risk. Claimant's counsel was instrumental in that regard.

For these reasons, absent the binding effect of Gamble, I would conclude that claimant is entitled to an attorney fee under ORS 656.386(1).

In Dykes v. SAIF, supra, the claimant broke his leg while taking an agility test. The test was a prerequisite for consideration for employment as a deputy sheriff. Claimant was not paid to take the test nor was there any promise of employment. As a reserve deputy, the claimant was not required to take the test. The court found that the claimant was not a subject worker because he was not under the direction and control of the employer nor was he furnishing services for remuneration. Specifically, the court rejected the claimant's argument that the possibility of future employment constituted remuneration under former ORS 656.005(31). In dicta, the court stated that "an employee who is injured while engaged in pre-employment training is *** performing services for the employer, namely, receiving training for the future benefit of the employer." 47 Or App at 190.

Perhaps because of my background as a labor negotiator, I place more emphasis on the parties' labor agreement. I find that the labor agreement fulfills the requirements set forth in ORS 656.005(28).

Here, the employer paid claimant $50 for his time for taking the test. The $50 payment is part of an agreement between the employer and the District Council of Laborers. This $50 payment applied to new hires. If claimant was not an employee "new hire," then the employer would not have been required to pay for the physical as required by the agreement. Cf. Martelli v. R.A. Chambers and Associates, 99 Or App 524 (1989)(remuneration contemplated a more direct quid pro quo between payment and services than the possibility that the worker's pay will ultimately come from the contract payment to his employer (subcontractor) from the general contractor). Thus, the $50 or $100 payment set forth in the agreement satisfies the requirement "engages to furnish services for remuneration."

In BBC Brown Boveri v. Lusk, supra, the claimant performed a welding test and participated in an orientation school. He failed the test and was not hired as a boiler maker. In finding that the claimant was not performing services for remuneration, the court rejected the argument that the preemployment test benefitted the employer by ensuring that it would employ only qualified workers. The court found that the claimant was not performing services for remuneration when his hearing loss was discovered.

The labor agreement also requires "new hires" to submit to a "fitness for duty exam." Claimant had no choice but to take the fitness test, and this was a contractual arrangement between the parties. Thus, unlike the claimant in Dykes, claimant was required to take the fitness test. In addition, claimant's "offer" of employment as a concrete laborer was conditioned on passing the fitness test. Given these circumstances, claimant was performing services for the employer. Also, the employer subsequently hired claimant. So, the statutory requirement "subject to the direction and control" of the employer is satisfied.

Thus, based on the contractual agreement, the $50 payment, and the eventual employment of claimant, I find that both elements of the statutory definition are met. Therefore, I would hold that claimant was a subject worker at the time of his injury.

I would further hold that any claim for injuries from this test fall under the Workers' Compensation Act. Perhaps I do this worker a disservice and should allow him the remedy of tort litigation against the employer, labor organization and test provider. But, the last time I looked, one of the purposes of the Act was to limit employer's liability from tort litigation. Therefore, I respectfully dissent.

Both of Dr. Butters' causation opinions are conclusory. Dr. Butters does not explain how any post-surgical immobilization caused claimant's right ulnar neuropathy condition. Furthermore, claimant has positive Tinel's signs over the ulnar nerves at both elbows, with radiation into the fifth finger. (Exs. 88A-2, 89-5, 100). Dr. Woolpert, examining orthopedist, opined that claimant's bilateral elbow symptoms raised the probability that claimant's elbow condition was idiopathic, rather than work-related. (Exs. 89-5, 100). Claimant's compensable injury involved his right shoulder. Dr. Butters offers no explanation for these bilateral ulnar symptoms when rendering his opinion that claimant's right ulnar condition is related to the compensable injury.

Given the lack of any explanation of his theory of causation, Dr. Butters' opinion does not establish that the compensable right shoulder injury is the major contributing cause of claimant's consequential right ulnar nerve condition. No other medical opinion supports claimant's position.

ORDER

The Referee's order dated July 22, 1993 is affirmed.

June 20, 1994 Cite as 46 Van Natta 1195 (1994)

In the Matter of the Compensation of
BURKE A. BUNNELL II, Claimant
WCB Case No. 93-04929
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Bethlahmy's order which upheld the SAIF Corporation's denial of claimant's cervical and low back injury claim. On review, the issue is subjectivity.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated September 13, 1993 is affirmed.

Board Member Gunn dissenting.

The majority holds that claimant is not a subject worker and therefore, the injury he sustained during a preemployment physical examination is not compensable. Because I would find that the $50 payment to claimant for taking the test is remuneration and that claimant was subject to the direction and control of the employer, I would hold that claimant was a subject worker. Accordingly, I dissent.

Claimant contends that he was a subject worker of the employer because:

1. he was furnishing services by performing a "fitness for duty exam" which would enable the employer to use his abilities to the employer's best advantage;

2. he received remuneration of $50 for performing the fitness test; and

3. he was subject to the direction and control of the employer, because the employer directed and required him to take the test.

In reaching its conclusion, the majority relies on the court's decisions in Dykes v. SAIF, 47 Or App 187 (1980) and BBC Brown Bovari v. Lusk, 108 Or App 623 (1991). I agree with claimant that these cases are distinguishable to the present case.

In their report, Drs. Brooks and Mayhall found that claimant's degenerative disc condition preexisted her injury and that such condition, rather than the compensable injury, was the cause of claimant's symptoms. (Ex. 23-4). Furthermore, the panel indicated that claimant's compensable injury had "healed" and that further low back symptoms likely would be because of her degenerative disc disease. (Id.) There was no indication that the work injury had worsened or affected the preexisting condition. Thus, because the report did not attribute the preexisting condition to claimant's compensable injury or work activities, we conclude that it did not constitute a "claim" for compensation for the preexisting degenerative disc disease. Consequently, claimant's request for hearing regarding this issue is premature and ineffective. See Syphers v. K-W Logging, Inc., supra; James A. Kinslow, 44 Van Natta 2119 (1992).

Inasmuch as the insurer has requested Board review and we have found that claimant's compensation awarded by the Referee's order should not be disallowed or reduced, claimant's attorney is entitled to an insurer-paid fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated September 3, 1993 is reversed in part and affirmed in part. Claimant's request for hearing regarding the compensability of a degenerative disc disease is dismissed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JOSEPH A. BARNES, Claimant
WCB Case No. 93-03819
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Livesley's order that upheld the self-insured employer's partial denial of claimant's right ulnar neuropathy condition. On review, the issue is compensability.

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

Claimant treated with Dr. Kuller, orthopedist, following his first compensable right shoulder surgery until Dr. Kuller referred him to Dr. Butters, orthopedist, in April 1989. (Ex. 21). Dr. Butters performed claimant's second compensable right shoulder surgery on June 23, 1989. (Ex. 25). Claimant did not seek treatment again from Dr. Kuller until February 1993. (Ex. 88-2). Although initially rendering an opinion that claimant's right ulnar condition was related to the compensable 1988 right shoulder injury, Dr. Kuller ultimately stated that she could not answer the compensability question and deferred to the opinion of Dr. Butters. (Exs. 90, 91, 96).

Dr. Butters offered two causation opinions. He initially stated that the right elbow condition was related to the 1988 injury and that he "would suspect" that the elbow condition was due to the immobilization after surgery. (Ex. 87A). However, a "suspicion" of a causal relationship does not rise to the level of the major contributing cause. Dr. Butters' also "checked-a-box" on a letter from claimant's attorney, indicating that post surgical immobilization of claimant's right arm was the major contributing cause of his elbow problems. (Ex. 98).

In the Matter of the Compensation of
MINDY L. AROLLA, Claimant
WCB Case No. 93-05511
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Myzak's order that set aside an alleged "de facto" denial of claimant's disc conditions. In its brief, the insurer asserts that claimant did not file a claim for degenerative disc disease and, alternatively, it did not "de facto" deny the compensability of such a condition. On review, the issues are the procedural validity of the request for hearing and, if valid, compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

In September 1992, claimant injured her low back. The insurer accepted a claim for lumbosacral strain. Claimant subsequently filed a request for hearing, asserting that the insurer had "de facto" denied the compensability of her "disc conditions."

As the Referee stated, claimant has three clinically different conditions in her low back: a lumbosacral strain, degenerative disc disease, and abnormal (herniated/bulging) discs. The Referee found claimant's abnormal discs compensable and ordered those conditions to be accepted by the insurer. Concerning the herniated/bulging discs, we adopt and affirm the Referee's findings of fact, analysis and conclusions of law. On that issue of compensability, the Opinion & Order is affirmed. Although the Referee discussed the compensability of claimant's degenerative disc disease in the body of her opinion, she did not issue an "order" regarding the compensability of such condition. We now address the status of the degenerative disc disease.

With regard to the degenerative disc disease, the insurer asserts that claimant did not file a claim for degenerative disc disease and, assuming that she did, the insurer did not "de facto" deny the compensability of such condition. Claimant responds that, because the Referee ordered the insurer only to accept the disc bulge and herniation, the insurer is requesting review concerning a condition for which it was not found liable.

We agree that the Referee ordered the insurer to accept only the L4-5 disc bulge and L5-S1 disc herniation. However, the Referee discussed the degenerative disc disease, finding that it had combined with the compensable injury and such resultant condition was compensable. Furthermore, claimant's request for hearing and his statement of the issue at hearing concerned the compensability of claimant's "disc conditions." (Tr. 2). Under these circumstances, we find that the compensability of the degenerative disc was raised at hearing and, therefore, it may be addressed on review. See Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458, 460 (1991).

A request for hearing is considered premature and ineffective if filed prior to a timely acceptance or denial or prior to the expiration of the time provided in ORS 656.262(6) for a carrier's acceptance or denial of a claim. E.g., Syphers v. K-W Logging, Inc., 51 Or App 769, 771, rev den 291 Or 151 (1981). A physician's report requesting medical services for a specified work-related condition constitutes a "claim." See Safeway Stores, Inc. v. Smith, 117 Or App 219, 227-28 (1993).

In this case, the first report mentioning degenerative disc disease was from Drs. Brooks and Mayhall, who examined claimant on behalf of the insurer. (Ex. 23). As noted by the Referee, the insurer received that report more than 90 days before the hearing. Although subsequent reports also discussed degenerative disc disease (Exs. 26, 27), the insurer did not receive them within 90 days before the hearing. Therefore, even assuming that such reports qualified as "claims", any request for hearing filed from such documents would be premature and ineffective. See Syphers v. K-W Logging, Inc., supra. Therefore, we consider only the report from Drs. Brooks and Mayhall in determining whether claimant filed a claim for degenerative disc disease.

Here, other than evidence confirming that claimant's at-injury wage was not affected by her return to modified work, there is essentially no documentary or testimonial evidence in the record regarding claimant's "earning power at any kind of work." In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work.

Because this record was developed prior to the court's interpretation of ORS 656.212 and its attention to diminished earning power at any kind of work in calculating TPD, the parties did not have an opportunity to present evidence or argument on this crucial issue. Therefore, we find that there is a compelling reason to remand for the submission of additional evidence solely concerning claimant's loss of earning power at any kind of work. See ORS 656.295(5); Lori A. Auterson, 46 Van Natta 262 (1994); Troy Shoopman, 46 Van Natta 21 (1994). At this "remand" proceeding, the parties are also requested to address the effect, if any, the Director's temporary amendments to OAR 436-60-003 and 436-60-030 have on this issue.[1] See WCD Admin Order 94-050.

Accordingly, this matter is remanded to the Presiding Referee with instructions to assign this case to a Referee to conduct further proceedings consistent with this order. Those proceedings may be conducted in any manner that the assigned Referee determines will achieve substantial justice, although we would recommend that evidence concerning claimant's employment history (including past/current wages) be presented. See Shoopman, supra at 22 n.2; see also WCD Admin. Order 94-050. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] We realize that the Board requested supplemental briefing from the parties regarding the effect, if any, these temporary rules have on this case. However, inasmuch as this case is being remanded to the Hearings Division for further proceedings regarding claimant's loss of earning power at any kind of work, the parties may address their arguments to the Referee regarding the applicability, effect and/or legality of these temporary rules.

In the Matter of the Compensation of
BABETTE STONE, Claimant
WCB Case No. 90-06254
ORDER ON REMAND (REMANDING)
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Stone v. Whittier Wood Products, 124 Or App 117 (1993), rev den 318 Or 459 (1994). The court reversed our prior order which found that claimant was not entitled to temporary partial disability (TPD) because she had been discharged from her modified job (which paid her regular wage) for reasons unrelated to her compensable injury. In reaching its conclusion, the court determined that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages, which is the test that we had applied in determining that claimant's TPD rate was zero. The court has remanded the matter for further proceedings applying the correct test.

FINDINGS OF FACT

We adopt the findings of fact contained in the Referee's order with the following supplementation. Claimant received her regular wage for the modified work she was performing prior to her termination.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right hand on February 2, 1989, and underwent carpal tunnel release surgery in August 1989. About August 23, 1989, claimant returned to modified work at the at-injury employer. She was paid her regular wage for this modified work. On September 11, 1989, claimant was terminated for reasons unrelated to her injury. Specifically, her employment was terminated for failure to comply with a "last chance agreement" by failing to participate in an alcohol treatment program. Computing claimant's TPD under OAR 436-60-030(2) at zero, the SAIF Corporation did not reinstate temporary disability benefits after claimant's discharge.

Claimant requested a hearing, raising the issue of TPD, among other issues. By order issued on September 19, 1990, as amended on October 18, 1990, Referee Miller concluded that claimant was not entitled to TPD after her termination because she had been terminated for reasons unrelated to her compensable injury and she was earning her regular wages for the modified work she was performing at the time of her termination. Claimant requested Board review of this order. On May 24, 1991, the Board affirmed and adopted Referee Miller's order. Claimant appealed the Board's order.

In Stone v. Whittier Wood Products, supra, the court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that OAR 436-60-030(2) was inconsistent with ORS 656.212, in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the court reasoned that an injured worker's 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. Specifically, the court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Consequently, the court remanded the case to the Board to determine whether claimant's partial disability caused a proportionate loss of earning power at any kind of work. In accordance with the court's mandate, we proceed to make that determination.

In the Matter of the Compensation of
AUDREY L. SANDERS, Claimant
WCB Case No. 93-02528
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Galton's order that: (1) found that the SAIF Corporation was not estopped from denying claimant's claim for medical services; and (2) declined to award an assessed attorney fee. On review, the issues are medical services and attorney fees.

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

On review, claimant argues that SAIF is estopped from denying her knee surgery, as a chart note authored by Dr. North, claimant's treating doctor, indicated that someone from SAIF had authorized the surgery. We disagree.

In Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992), the court held that the doctrine of equitable estoppel is only intended to protect those who materially change their position in reliance upon another's acts or representation. However, in the present case, we do not find that claimant has established that she materially changed her position in reliance upon the alleged authorization from SAIF.

Here, Dr. North's earlier chart notes explained that claimant had a meniscus abnormality which was probably due to the industrial accident. Dr. North further stated that claimant also had a preexisting arthritis condition in the same knee and arthroscopic surgery was needed to identify the extent of the derangement and to determine the proper treatment. Following an MRI, Dr. North found "some" internal derangement, but "mostly chondromalacia type grinding" in the patellar area. Dr. North stated that after discussing the options, "we have agreed to proceed with arthroscopic debridement," and if necessary, surgery to "unload the patellar chondromalcia." Dr. North then noted that, "[o]nce authorization had been obtained," claimant would return for a conference regarding the surgery.

Thereafter, Dr. North noted that "[a]uthorization received from Ginger at SAIF. The claim is still in a deferred status." Shortly after this note, Dr. North performed the surgical procedure.

Following the surgery, SAIF accepted a horizontal and lateral meniscus tear of the left knee. Dr. North agreed with the opinion of SAIF's medical advisor that, with the exception of the menisectomy, the major contributing cause of the surgical procedure was claimant's preexisting degenerative condition.

From the record, we conclude that claimant and Dr. North were aware that claimant had both a preexisting condition and some internal knee damage that was possibly related to the industrial injury. However, there is no indication that claimant only decided to proceed with the surgery based upon SAIF's representation that the surgery was authorized. Rather, the record establishes that it was following discussion of the options that claimant and Dr. North decided to proceed with surgery. In other words, claimant has not proven that the decision to undergo surgery was expressly contingent upon receiving authorization from SAIF. Furthermore, Dr. North's note regarding authorization was followed by his comment that the claim was "still in deferred status." Finally, there was no testimony provided by claimant which would support a finding that claimant materially changed her position in reliance upon SAIF's acts or representations.

Under the circumstances, we agree with the Referee that equitable estoppel does not apply to require SAIF to pay for claimant's surgery.

ORDER

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

Regardless of which doctor is found to be the most persuasive, none of the medical opinions state with reasonable certainty supported by objective findings that claimant's nondisabling right ankle sprain was the major contributing cause of his right ankle condition. Instead, the evidence preponderates against any such causal connection. Claimant has a long history of pain symptoms and disability as a result of his congenital rickets condition. (e.g., Dr. Goins testified that the pain symptoms claimant was experiencing as a result of his right ankle condition were identical to previous pain complaints solely attributable to the rickets condition. Ex. 21-17). All the physicians agree that the rickets condition has contributed significantly to claimant's right ankle condition.

The majority relies upon Dr. Walton as establishing the requisite "major" causal connection. However, a close examination of Dr. Walton's opinions reveal a marked uncertainty regarding the relative contribution that claimant's preexisting rickets had upon the right ankle condition. Specifically, in a concurrence with Dr. Woolpert's finding that claimant's preexisting rickets condition was the major contributing cause of his right ankle condition, Dr. Walton stated: "There is no question that I agree with Dr. Woolpert that he has underlying factors that are contributing . . . The crux of the matter is, and I do not know whether this answer is 'knowable,' is the degree to which these factors affect Mr. Rivera's problem." (Ex. 20-2). Dr. Walton subsequently recanted his concurrence, but offered no alternative explanation based upon medical probability. Dr. Walton's conclusion regarding major contributing cause never rises above speculation.

The Referee was correct in stating that no medical opinion in the record establishes a "major contributing" causal connection between claimant's July 1992 right ankle injury and his subsequent right ankle condition and need for treatment based upon more than medical possibility. The medical evidence is insufficient where it does not show with reasonable certainty (not mere possibility) that claimant's October 1992 injury is the major contributing cause of his resultant condition and need for treatment. See Gormley v. SAIF, 52 Or app 1055, 1059 (1981). Therefore, claimant necessarily fails in establishing the compensability of his condition by a preponderance of the evidence.

The evidence within the record is, at best, in equipoise regarding the issue of major contributing cause. Therefore, the quantum of proof is inadequate to meet claimant's burden. Because I believe the majority position to be in error, I respectfully dissent.

At deposition Dr. Walton agreed with claimant's attorney's statement that: ". . . isn't it more likely than not that the industrial injury was the major cause of the pain which caused him to go in for treatment." (Ex. 22-14). Furthermore, Dr. Walton testified that he suspects claimant's right ankle injury to be the major contributing cause based upon the elimination of other reasons. (i.e., claimant has not experienced any other discrete injuries and a simple right ankle sprain should have quickly resolved). (Ex. 16-20, 21). Additionally, although unable to make a specific diagnosis, Dr. Goins opined that all the differential diagnoses surrounding claimant's right ankle were attributable to the original sprain of July 1992. (Ex. 11).

We acknowledge that none of the medical experts state explicitly that claimant's right ankle injury of July 13, 1992 is the major contributing cause of claimant's right ankle condition and need for treatment. Yet, it is not necessary to use "magic words" in order to satisfy the major contributing cause test. It is sufficient that the medical evidence as a whole supports the conclusion that claimant's compensable right ankle injury of July 1992 was the major contributing cause of claimant's resultant condition. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). We conclude that Dr. Walton's opinion satisfies claimant's requisite burden of proof.

Moreover, we are impressed by the fact that Dr. Walton was able to finally resolve claimant's right ankle condition. In a May 18, 1993 letter responding to an inquiry from claimant's attorney, Dr. Walton stated:

> "Currently, [claimant] is in a nonweightbearing casted situation for two months. If he continues to be symptomatic following this type of immobilization, I would concur that the current symptoms are not related to the accident." (Ex. 20-2).

Claimant testified that this last course of treatment was successful and his pain symptoms did finally resolve. The subsequent resolution of claimant's right ankle condition provides further implicit support for Dr. Walton's opinion that claimant's compensable July 1992 injury, rather than rickets, was the major contributing cause of his disability and need treatment.

Finding no reasons to do otherwise, we give more weight to the opinion of claimant's treating physician. Weiland v. SAIF, supra. Moreover, we find Dr. Walton's explanations regarding the major contributing cause of claimant's right ankle disability and need for treatment to be persuasive. Therefore, we conclude that claimant has successfully demonstrated by a preponderance of the evidence that his compensable July 1992 right ankle condition is the major contributing cause of his resultant right ankle condition. See ORS 656.005(7)(a)(B). Accordingly, the Referee's order is reversed and the self-insured employer's denial is set aside.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's right ankle condition is $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 22, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing in accordance with the law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $3,500, payable by the self-insured employer.

Board Member Haynes dissenting.

The majority concludes that claimant has proven by a preponderance of the evidence that his nondisabling right ankle sprain of July 13, 1992 was the major contributing cause of his resultant right ankle disability and need for treatment. Because I believe that claimant has not met the burden of proof required under ORS 656.005(7)(a)(B), I respectfully dissent.

In the Matter of the Compensation of
MICHAEL A. RIVERA, Claimant
WCB Case No. 92-14279
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband, Hall, and Haynes.

Claimant requests review of Referee Spangler's order that upheld the self-insured employer's denial of claimant's right ankle condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current right ankle condition was not compensable. In reaching this conclusion, the Referee reasoned that claimant's compensable right ankle strain of July 1992 was not the major contributing cause of his current condition and need for treatment. We disagree.

It is undisputed that claimant has congenital, vitamin D resistant rickets. It is also undisputed that the preexisting condition combined with the compensable injury to cause disability and need for treatment. Therefore, in order to prove the compensability of his current condition, claimant must establish that his compensable injury is the major contributing cause of his current condition. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We conclude that claimant has sustained his burden of proof.

Claimant's lifelong history of disability and need for treatment as a result of his rickets condition makes the causation issue in this case a medically complex question. Therefore, resolution of this issue turns largely on the medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

There are three medical opinions. Claimant's treating physician, Dr. Walton (orthopedic surgeon), and Dr. Goins (neurologist) both believe that claimant's compensable injury of July 1992 is the most significant factor contributing to his current right ankle condition and need for treatment. The third medical opinion comes from Dr. Woolpert (orthopedic surgeon) who examined claimant at the request of SAIF. Dr. Woolpert states categorically that claimant's preexisting rickets condition, rather than the compensable ankle strain, is the major contributing cause of his current condition.

The employer contends that no medical opinion rises to a level above mere possibility so as to establish a "major contributing" causal connection between claimant's July 1992 right ankle injury and his subsequent right ankle condition and need for treatment. The employer urges that we adopt the Referee's conclusion that Dr. Woolpert's medical opinion is the most persuasive.

Dr. Woolpert opined that claimant's congenital rickets condition (specifically: spurring and increased uptake in both ankles bilaterally, related to preexisting process) was the major cause of his right ankle complaints and need for treatment. (Ex. 17-5, 6). Claimant's treating physician, Dr. Walton, and Dr. Goins concurred with Dr. Woolpert's opinion. (Exs. 19 & 20). Dr. Walton subsequently recanted his concurrence. (Ex. 22-14).

Claimant argues that the Referee erred when he found Dr. Woolpert's medical opinion to be the most persuasive. Claimant contends that Dr. Walton has been treating claimant throughout the course of this right ankle condition and should be afforded the deference traditionally given an attending physician. See Weiland v. SAIF, 64 Or App 810 (1983); Taylor v. SAIF, 75 Or App 583 (1985). We agree.

Because Liberty accepted a "temporary exacerbation of chronic lumbosacral strain," AIAC contends that responsibility for claimant's low back condition necessarily shifted to Liberty. ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

After further consideration, we agree that by accepting claimant's claim for a back injury, Liberty conceded that the condition was compensable, i.e. that a new compensable injury had occurred. See Smurfit Newsprint v. DeRosset, 118 Or App 368, 372 (1993) (carrier's acceptance was a concession that claim was compensable). As the insurer responsible for the most recent accepted claim for claimant's low back condition, Liberty would also be responsible for future compensable medical services and disability for the compensable condition. See ORS 656.308; Smurfit Newsprint v. Derosset, supra at 371.

We also conclude that the March 1992 injury at Liberty's insured involved the same condition as the June 1991 AIAC injury. See ORS 656.308(1); Smurfit Newsprint v. Derosset, supra. Although Liberty accepted a "temporary exacerbation of chronic lumbosacral strain," the medical record indicates that claimant's March 1992 injury, like her June 1991 injury, involved a lumbosacral strain. Under such circumstances, we conclude that claimant suffered a new compensable injury at Liberty's insured which involved the same condition that AIAC had previously accepted. Inasmuch as that same condition is the low back condition which is presently under dispute, Liberty remains responsible for that condition.

Although compensability was not raised on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for services on review. ORS 656.382(2).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, 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.

Accordingly, our March 17, 1994 order is withdrawn. On reconsideration, the Referee's order dated June 17, 1993 is affirmed. For services on review, claimant's attorney is awarded $750, payable by Liberty.

IT IS SO ORDERED.

The carrier argued that, because the claimant's preexisting degenerative disease was the major contributing cause of her current disability, its denial was procedurally valid. The court disagreed, finding nothing in the text or context of ORS 656.005(7)(a)(B) to suggest that the legislature intended that provision to provide carriers with the procedural authority to deny accepted claims. Id. at 257. Consequently, the court held that, if a carrier determines that a compensable injury is no longer the major contributing cause of a worker's disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268. Id.; see also Jean K. Elliott-Moman, 46 Van Natta 991 (1994) (applying Brown).

The Brown court's reasoning is inconsistent with our reasoning in Bakke regarding ORS 656.005(7)(a)(B). Accordingly, we conclude that our analysis in Bakke regarding ORS 656.005(7)(a)(B) is no longer valid law. We therefore reject the insurer's argument based on that analysis.

Claimant is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by the insurer. In reaching this decision, 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 September 13, 1993 is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by the insurer.

June 17, 1994 Cite as 46 Van Natta 1185 (1994)

In the Matter of the Compensation of
BONNI J. MEAD, Claimant
WCB Case Nos. 93-03486 & 93-02288
ORDER ON RECONSIDERATION
Robert G. Dolton, Claimant Attorney
Roberts, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

American International Adjustment Company, Inc. (AIAC), requests reconsideration of our March 17, 1994 Order on Review which held that responsibility for claimant's low back condition remained with AIAC. On April 15, 1994, we withdrew our order for reconsideration.

In our prior order, we held that responsibility never shifted from AIAC to Liberty since claimant did not sustain a new compensable injury at Liberty's insured. In concluding that claimant had not sustained a new compensable injury, we relied on the uncontroverted medical evidence which established that the major contributing cause of claimant's low back condition was the June 1991 compensable injury at AIAC's insured. Specifically, we relied on SAIF v. Drews, 318 Or 1 (1993), to hold that pursuant to ORS 656.005(7)(a)(B), claimant had not sustained a new compensable injury at Liberty's insured.

On reconsideration, AIAC argues that because of Liberty's acceptance of claimant's claim, it was relieved of the burden imposed by ORS 656.308(1) of establishing that claimant sustained a new compensable injury. After further consideration of the matter, we withdraw our prior order and issue the following order.

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

Claimant sustained a compensable injury to her low back while working for AIAC's insured on June 22, 1991. On March 18, 1992, claimant again injured her low back while employed by Liberty's insured. On February 4, 1993, Liberty accepted the claim for "temporary exacerbation of chronic lumbosacral strain." On the same date, Liberty partially denied claimant's current chronic lumbosacral strain condition. AIAC denied responsibility for claimant's low back condition on March 10, 1993. On May 14, 1993, Liberty issued a second partial denial of claimant's current low back condition.

Having concluded that claimant received notice of the medical arbiter's examination, the remaining question is whether claimant waived his right to a medical arbiter's examination. In Craig K. Witt, 45 Van Natta 1285 (1993), we concluded that a claimant waived his right to a medical arbiter exam when he failed to attend the examination because he escaped from the correctional facility where he was incarcerated. Like the Referee, we find Witt controlling. Because he failed to attend the medical arbiter's examination, without mitigating or just cause, claimant waived his right to a medical arbiter's examination. See OAR 436-30-050(11)(a) (if the worker or the worker's representative requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order).

Finally, we note that subsequent to the date of the Referee's order, the Court of Appeals held that the validity of an Order on Reconsideration is not a prerequisite for determining jurisdiction. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Accordingly, regardless of whether the Order on Reconsideration was invalid, the Referee had jurisdiction to hear this case and review the Order on Reconsideration.

ORDER

The Referee's order dated August 27, 1993 is affirmed.

In the Matter of the Compensation of
JOHN M. LAMPMAN, Claimant
WCB Case No. 92-15800
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Referee Holtan's order that: (1) set aside its "back up" denial of claimant's breathing difficulties, coughing and wheezing; and (2) set aside its partial "current condition" denial of claimant's accepted respiratory condition. On review, the issues are the propriety of the insurer's "back up" denial, the procedural validity of the insurer's "current condition" denial and, if the denials are proper and valid, the compensability of claimant's original and current conditions.

We adopt and affirm the Referee's order, with the following supplementation regarding the validity of the insurer's "current condition" denial.

Relying on Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984), the Referee concluded that the insurer had issued a procedurally improper preclosure "current condition" denial of claimant's accepted respiratory condition. On review, the insurer argues that its "current condition" denial was valid under ORS 656.005(7)(a)(B) and the Board's holding in Daniel R. Bakke, 44 Van Natta 831 (1992). We disagree.

In Bakke, we held that, under ORS 656.005(7)(a)(B), when a carrier obtains evidence that a worker's disability is not then caused in major part by the compensable injury, but rather, by a preexisting condition, the carrier may partially deny compensation for the then-current resultant condition. Id. at 833.

Subsequent to the Referee's order and the briefing on review in this matter, the Court of Appeals issued its decision in United Airlines, Inc. v. Brown, 127 Or App 253 (April 20, 1994), in which it held that a carrier's preclosure "resultant condition" denial under ORS 656.005(7)(a)(B) is not procedurally valid where the claim has not first been closed. The court affirmed a Board order holding that a carrier's "resultant condition" denial under ORS 656.005(7)(a)(B) did not entitle the carrier to discontinue payment of the claimant's temporary disability benefits while the claim was in open status.

In the Matter of the Compensation of
MARIO M. LABRA, Claimant
WCB Case No. 93-05317
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee McCullough's order that affirmed an Order on Reconsideration which did not award unscheduled permanent disability for a neck, right shoulder and back injury. In his brief, claimant objects to the Referee's reopening of the record for additional evidence. On review, the issues are the validity of the Order on Reconsideration, the extent of unscheduled permanent disability and evidence.

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

Claimant's claim was closed by a September 10, 1992 Determination Order which awarded no permanent disability. On March 2, 1993, claimant, through his attorney, requested reconsideration of the Determination Order and also requested a medical arbiter examination. A medical arbiter examination was scheduled, and on March 24, 1993, notice of the examination was sent to the same address given by claimant in his request for reconsideration. However, claimant did not attend the examination. Although claimant testified that he moved on January 31, 1993, there is no evidence that claimant notified the Department or his attorney that his address had changed. An Order on Reconsideration issued on April 26, 1993 which affirmed the Determination Order based upon the record developed at the time of claim closure. Claimant requested a hearing on the Order on Reconsideration.

A hearing was held on August 2, 1993. The sole issue raised at the commencement of the hearing and by the pre-hearing pleadings was the extent of unscheduled permanent disability. Although claimant testified that he had not received notice of the medical arbiter examination, claimant did not raise the invalidity of the reconsideration order until closing argument. After closing arguments were completed, the Referee closed the record.

Approximately ten minutes after the record closed, the Referee reopened the record on the insurer's motion, for testimony from Mr. Fisher, the employer representative. Fisher testified that claimant brought the notice of the medical arbiter examination with him to work and that Fisher saw it and told claimant he needed to attend the appointment. The Referee reopened the record and allowed Mr. Fisher's testimony to be taken. The Referee also left the record open for any rebuttal testimony which claimant chose to offer, but claimant declined the opportunity to provide rebuttal testimony.

Based in part on the testimony of Mr. Fisher, the Referee found that claimant received notice of the medical arbiter examination and concluded that claimant waived his right to a medical arbiter examination. On review, claimant objects to the Referee's decision to allow the record to be reopened.

We need not resolve claimant's evidentiary objection because, even if we do not consider the testimony of the employer representative, we remain unpersuaded that claimant was not constructively notified of the medical arbiter examination. In this regard, there is no evidence that claimant advised the Department or his attorney of a change of address and no proof that the notice of the medical arbiter examination was returned to the Department as undeliverable. In fact, the address claimant gave in his March 2, 1993 request for reconsideration was the same address to which the Department mailed its notice of the medical arbiter examination on March 24, 1993. In addition, even though the hearing notice was mailed to the same address that the notice of the medical arbiter examination was mailed, the notice of hearing was not returned as undeliverable and claimant did not testify that he failed to receive the notice of hearing.

Based on this evidence, we are unable to conclude that claimant did not receive notice of the medical arbiter examination. Accordingly, we find it unnecessary to address the evidentiary issue since we conclude, based upon other evidence in the record, that claimant has not established that he did not receive notice of the medical arbiter examination.

In the Matter of the Compensation of
KIM J. HAYES, Claimant
WCB Case No. 93-00798
and, In the Matter of the Compensation of
PAULA O. ZENOR, Claimant
WCB Case No. 92-14987
and, In the Matter of the Complying Status of
TWO D'S TRUCKING, INC., Employer
WCB Case No. 92-12689
ORDER ON RECONSIDERATION
James B. Griswold, Claimant Attorney
Malagon, et al., Claimant Attorneys
William J. Blitz, Attorney
Gail Gage (Saif), Defense Attorney

Two D's Trucking, Inc., an alleged noncomplying employer, has requested reconsideration of our May 26, 1994 Order on Review which affirmed a Referee's order which: (1) found Kim J. Hayes and Paula Zenor to be subject workers for Two D's Trucking; (2) affirmed The Proposed and Final Order Declaring Noncompliance and Assessing a Civil Penalty; and (3) found that the SAIF Corporation, on behalf of Two D's Trucking, was responsible for the processing of Kim J. Hayes' and Paula Zenor's claims. Specifically, Two D's Trucking contends that we erred in not addressing the effect of ORS 656.029 on this matter. After considering Two D's Trucking's motion and memorandum in support and claimants Hayes' and Zenor's memorandums in opposition, we issue the following order.

To begin, the Referee's order, which we adopted, did address Two D's Trucking's contention that ORS 656.029 requires other parties, which it alleges employed the claimants, be a party to these proceedings. In addition, Two D's Trucking's argument is based on an alleged contract between other companies and the claimants. However, the issue before us is whether there was an employment relationship between the claimants and Two D's Trucking. By adopting the Referee's finding that the claimants were subject workers of Two D's Trucking, we agreed that such a relationship existed. In this regard, we note that Two D's Trucking's position that claimants were corporate officers is directly contrary to its assertion that they were allegedly employed by other companies.

Moreover, Two D's Trucking's contention focuses on the contract for services (hauling cargo) between Two D's Trucking and the out-of-state companies. Again, the issue in this case is the employment contract between Two D's Trucking and claimants. Thus, the service contract between Two D's Trucking and the other companies has little relevance to the issue in dispute.

Finally, we do not find that Astleford v. SAIF, 122 Or App 432 (1993) compels a different result. While ORS 656.029 may provide a defense against noncompliance in some cases, it does not do so in this case. First, Two D's Trucking employed other workers besides the claimants and did not provide workers' compensation coverage for those workers. Second, as noted above, we have concluded that claimants were subject workers of Two D's Trucking. Thus, we would still conclude that Two D's Trucking was a noncomplying employer.

Accordingly, our May 26, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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

ORDER

The Referee's order dated September 3, 1993 is reversed in part and affirmed in part. That portion which impliedly upheld the employer's April 1993 denial of claimant's current condition is reversed. The April 7, 1993 denial is set aside and claimant's current cervical and thoracic condition is to be processed as part of the July 1992 claim. The remainder of the Referee's order is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the self-insured employer.

June 17, 1994 Cite as 46 Van Natta 1181 (1994)

In the Matter of the Compensation of
LEOLA M. DAVIS, Claimant
WCB Case No. 93-01817
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's denial of claimant's current left knee condition. On review, the issue is compensability.

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

Claimant has an accepted claim for left knee contusion as a result of an October 1992 industrial accident. In December 1992, claimant sustained a non-work related right ankle sprain. On January 10, 1993, claimant experienced a spontaneous onset of left knee pain; an MRI revealed a torn meniscus. Claimant also has preexisting degenerative disease in her left knee.

Applying ORS 656.005(7)(a)(B), the Referee concluded that claimant had failed to prove that the October 1992 compensable injury was the major contributing cause of her need for treatment and disability and, therefore, compensability was not established. Relying on U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), claimant asserts that she proved compensability. We disagree.

In Burtis, the medical evidence established that the claimant's "resultant condition" was the claimant's cervical strain superimposed on his degenerative cervical spine disease, and that the compensable injury was the major contributing cause of his disability and need for treatment. Here, we agree with the Referee's assessment of the medical opinions and the Referee's finding that the record contained no persuasive medical evidence showing that the October 1992 industrial accident was the major contributing cause of the meniscus tear. We cannot find, based on the evidence in this record, that claimant's compensable condition is the major contributing cause of the need for treatment. Consequently, we find this case distinguishable from Burtis.

ORDER

The Referee's order dated September 20, 1993 is affirmed.

The employer contends, however, that the totality of Dr. Hearns' medical opinion supports a conclusion that the July episode was only an aggravation or continuation of the 1989 injury. The employer cites Dr. Hearns' initial opinion wherein he stated that claimant's complaints were similar to those treated as a result of the 1989 injury. (Ex. 21-3). Dr. Hearns also appeared to describe the July 1992 incident as an aggravation rather than as a new injury.

However, the issue is whether the July 1992 incident was the major contributing cause of claimant's need for medical treatment. ORS 656.005(7)(a)(B). In view of Dr. Hearns' explicit testimony that the reason for claimant's medical treatment was the July 1992 incident, we are persuaded that the major factor in claimant's need for treatment was that specific traumatic episode.

In addition, claimant's counsel read to Dr. Hearns the specific passage from the medical report on which the employer relies. (Tr. 31). After having his memory refreshed regarding his earlier opinion, Dr. Hearns still testified that the July 1992 incident caused him to treat claimant and that this was a new insult to previously injured tissues and body parts. Dr. Hearns subsequently testified that the July 1992 trauma was a "significant" factor in claimant's need for medical treatment. (Tr. 33). While Dr. Hearns never used the "magic words" major contributing cause, it is well-settled that no incantation of statutory language is necessary to satisfy medical causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986); Shelley C. Nikolaus, 46 Van Natta 458, 460 (1994).

In light of Dr. Hearns' testimony, given after he heard claimant's testimony and was reminded of his prior medical opinion, we are persuaded that the medical evidence from Dr. Hearns supports our conclusion that the July 1992 incident was the major causal factor in claimant's need for treatment. Thus, claimant's medical care is compensable as a "new injury" claim.

Current Condition

In April 1993, the employer denied claimant's "current" thoracic and cervical condition on the grounds that it was not related to the 1989 compensable injury. The Referee concluded that, if his determination that claimant suffered a new compensable injury in July 1992 was wrong, then he would alternatively find that claimant's 1989 injury was the major contributing cause of claimant's current condition and need for treatment. However, the Referee's order did not reverse the employer's April 1993 denial. Thus, the Referee's order impliedly upholds the current condition denial.

On review, the employer contends that claimant's underlying degenerative disc disease is the major contributing cause of his cervical and thoracic condition after Dr. Hearns' treatment ended in November 1992. Therefore, his current condition is not compensable. We disagree.

Since it is responsible for the most recent accepted claim for claimant's cervical and thoracic condition (July 1992), the employer remains responsible for claimant's future medical treatment for the "compensable condition," unless claimant sustains a new compensable injury involving the "same condition." See ORS 656.308(1). In this case, there is no evidence that claimant suffered a new compensable injury after the July 1992 incident, which we have determined to be a new injury. There is also no evidence that claimant's cervical and thoracic condition had changed when Dr. Kelty assumed claimant's care in December 1992. Therefore, the employer remains responsible for claimant's medical treatment under the July 1992 claim. See Smurfit Newsprint v. DeRossett, 118 Or App 368, 371 (1993). Moreover, we are persuaded that claimant's compensable July 1992 injury remains the major contributing cause of his need for treatment.

Although the employer solicited medical reports from Drs. Hearns and Zivin that concluded that claimant's degenerative disc disease became the major contributing cause of his need for treatment after November 1992, those opinions were expressed in conclusory check-the-box reports. (Exs. 36-3, 37-4). Because of this, they are entitled to little weight. See Gary Wallace, 46 Van Natta 258, 260 (1994).

Moreover, Dr. Hearns provided no analysis in his hearing testimony to support his conclusory opinion regarding the causation of claimant's current cervical and thoracic conditions. While we have found Dr. Hearns' testimony regarding the causation of claimant's condition in July 1992 to be persuasive, his failure to adequately explain his medical opinion concerning claimant's current condition does not rehabilitate the conclusory opinion expressed in his concurrence letter. Thus, we find that claimant's current cervical and thoracic condition is compensable as part of the July 1992 claim, the most recent compensable claim involving the same condition. ORS 656.308(1). Inasmuch as the Referee impliedly upheld the April 1993 denial, we reverse that portion of the Referee's order.

November 1992. The employer paid for claimant's treatment under the 1989 claim. At hearing, claimant contended that his medical treatment in 1992 should be processed as part of a "new injury" claim.

The Referee found that the employer had failed to respond to a "claim" in September 1992 and that this constituted a "de facto" denial. Reasoning that the medical evidence established that the July 1992 incident was a "material contributing cause" of claimant's need for treatment, the Referee concluded that claimant had sustained a "new injury" rather than an aggravation of the 1989 injury. Citing Peggy Holmes, 45 Van Natta 278 (1993), the Referee remanded the claim to the employer for claim processing in accordance with his determination.

Subsequent to the Referee's order, the Supreme Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). SAIF v. Drews, 318 Or 1 (1993). We have conformed the test for distinguishing new injuries from aggravations in cases involving the same employer with current responsibility law. See Peggy Holmes, supra, 45 Van Natta at 279. Thus, claimant sustained a new injury for claim processing purposes if the July 1992 incident is "the major contributing cause" of his need for treatment.

Here, because of the passage of time since claimant's initial cervical and thoracic injury and the presence of underlying degenerative disc disease, the causation issue is medically complex, requiring expert medical evidence for its resolution. See Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Drs. Kelty, Zivin, Geist and Hearns provided the medical evidence concerning the causation issue. Dr. Kelty, a chiropractor, treated claimant beginning in December 1992. He agreed that the July 1992 incident contributed to a myofascial condition resulting from the 1989 injury. (Ex. 36A). Dr. Kelty also confirmed that the primary reason for his treatment was not degenerative disc disease, but rather myofascial pain and fibrositis due to the 1989 injury. Id. However, Dr. Kelty's opinion is insufficient to establish that claimant's July 1992 accident is the major contributing cause of his need for treatment.

Drs. Zivin and Geist examined claimant on behalf of the employer. (Ex. 32) They concluded that claimant required treatment for symptomatic flare-ups of his degenerative disc disease because specific incidents at work triggered intensified symptoms. Moreover, Drs. Zivin and Geist stated that claimant would not be receiving treatment for his dorsal spine but for his injurious work incidents, including the July 1992 episode. While not especially detailed, the Zivin-Geist opinion lends support to claimant's position that he sustained a new injury in July 1992. We emphasize that claimant need only establish that the July 1992 incident was the major causal factor in his need for treatment.

Dr. Hearns, the doctor who treated claimant the most contemporaneously with the July 1992 episode, testified that he treated claimant because of the July incident. (Tr. 31). Dr. Hearns further testified that the July incident was a "new insult" to previously injured soft tissue and body parts. Id. Although Dr. Hearns based his opinion on claimant's testimony that he was experiencing only occasional, relatively minor symptoms prior to the July 1992 occurrence and that he had not sought treatment for approximately one year before that incident, this history is supported by the record. The documentary evidence does not indicate claimant received medical treatment for nearly a year prior to the July 1992 episode. The employer presented no evidence rebutting claimant's testimony that he was doing relatively well prior to July 1992 and that since that time, his pain has become much more severe and frequent.

We are mindful of Dr. Hearns' testimony that questioned how traumatic the July 1992 incident was, given that claimant did not seek treatment until two months after the incident. (Tr. 35). We have given that testimony, as well as the timing of claimant's initial treatment, careful consideration. However, given the lack of evidence directly rebutting claimant's testimony concerning the course of his symptoms, we accept as accurate claimant's history of substantially increased symptoms, both in terms of severity and frequency, after the July episode.

Thus, Dr. Hearns' testimony, coupled with the Zivin-Geist medical opinion, persuades us that the July 1992 incident was the major contributing cause of claimant's need for treatment in September 1992 and therafter. Accordingly, we find that claimant's medical treatment related to the July 1992 incident should be processed as a "new injury" claim, as the Referee determined.

In the Matter of the Compensation of
KAREN A. SEPICH, Claimant
WCB Case Nos. 93-05884 & 93-05883
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Baker's order which: (1) increased claimant's unscheduled permanent disability for a low back injury from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to 12 percent (38.4 degrees); and (2) increased claimant's unscheduled permanent disability award for a contact dermatitis condition from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 38 percent (121.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

Claimant is a 28 year old registered nurse who worked in the intensive care unit of the employer's hospital. On October 25, 1991, claimant compensably injured her low back while assisting in moving a 300 pound patient. A September 21, 1992 Notice of Closure closed the low back claim with an award of 5 percent unscheduled permanent disability. Claimant requested reconsideration. By Order on Reconsideration dated May 4, 1993, the award was increased to 6 percent. The Reconsideration Order was subsequently abated and withdrawn for further consideration in light of the Supreme Court's decision in England v. SAIF, 315 Or 633 (1993). The Amended Order on Reconsideration issued on July 27, 1993 and awarded 7 percent unscheduled permanent disability. Claimant's low back condition was found medically stationary on August 18, 1992.

In April 18, 1992, claimant suffered an acute flare-up of a chronic dermatitis condition. Claimant's condition was diagnosed as irritant contact dermatitis with associated latex allergy. Her condition was found medically stationary on January 8, 1993. The employer closed the claim by Notice of Closure dated January 28, 1993, with awards of 3 percent scheduled permanent disability for the right and left hand, respectfully. A May 11, 1993 Order on Reconsideration awarded an additional 3 percent unscheduled permanent disability of the integumentary system.

CONCLUSIONS OF LAW AND OPINION

Low Back Condition

The parties only contest the adaptability factor. Based on claimant's testimony, the Referee found that claimant's job as an intensive care nurse required heavy lifting. The Referee further found that claimant has been restricted to light work. Relying on temporary OAR 436-35-310, the Referee, therefore, determined that claimant was entitled to an adaptability value of 5. We modify.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2); See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant became medically stationary on August 18, 1992 and his claim was closed by Notice of Closure on September 21, 1992. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the Notice of Closure. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 6-1992.

The adaptability factor is based on a comparison of the strength demands of the worker's job at time of injury with the worker's maximum residual functional capacity (RFC) at time of determination. Former OAR 436-35-310(1). Former OAR 436-35-270(3)(g) provides that "'[s]trength' means the physical demands of each job as described by the SCODDOT. Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury."

In addition, while we consider the record as a whole, including the job duties and the physical demands of the at-injury job, in determining which DOT is most applicable, the fact remains that the most applicable DOT determines the strength category of the at-injury job. See William L. Knox, 45 Van Natta 854 (1993). Claimant's testimony is relevant to the determination of which DOT most accurately describes her at-injury job. Kathyron D. Parsons, 45 Van Natta 954 (1993).

Here, claimant contends that the DOT job description of an orderly more appropriately describes her job since she was required to lift and transfer patients. The SCODDOT description of an orderly lists a worker's duties as bathing patients; measuring and recording intake and output of liquids, temperature, pulse and respiration; feeding patients; lifting patients onto and from bed, and transporting patients to other areas, by rolling a bed or using a wheelchair or stretcher; making beds; and cleaning rooms. The orderly job is classified as heavy work. DOT 355.674-018. The job description of a nurse includes tasks such as administering medications and treatment, observing patients, taking and recording vital signs, and making beds, bathing and feeding patients. The job requires medium strength. DOT 075.364-010.

Claimant's job title was staff registered nurse in intensive care. Her duties included caring for critically ill patients, monitoring patients, administering medications, turning and lifting patients, taking and recording vital signs, and bathing patients. (Tr. 9-10). Claimant testified that she lifted 50 pounds on a daily basis (Tr. 10). She also testified that she possibly lifted more than 100 pounds, but did not state the frequency of this lifting.

This testimony is insufficient to prove "heavy work," which is defined in the standards as lifting 100 pounds maximum with frequent (from 1/3 to 2/3 of the time) lifting and/or carrying objects weighing up to 50 pounds. Former OAR 436-35-270(g)(D). Even though claimant's job involved some work in the "orderly" job description, we find that claimant's at-injury job is most appropriately defined as "nurse."

Dr. Ward, claimant's treating physician for her low back injury, released claimant to return to her regular job, with the recommendation to obtain assistance for lifting, pushing, and pulling patients. (Exs. 28, 30). The medical arbiters opined that if claimant returned to critical care work, she must use proper body mechanics. They concluded that claimant was capable of medium work occasionally and light work constantly, with no repetitive bending, stooping, and crouching.

RFC is determined from the greatest capacity evidenced by the attending physician's release, the preponderant medical opinion or the strength of any job to which the worker has "returned to work." Former OAR 436-35-270(3)(d)(A)-(C). Because claimant's job at-injury required "medium" strength and she was released to that job with restrictions, claimant's adaptability factor is 2. Former OAR 436-35-310(1) and (3).

Pursuant to OAR 436-35-280(6), the adaptability value of two (2) is multiplied by the values for age and education (1) for a total of two (2). This value is added to the value for impairment (6) for a total of 8 percent unscheduled permanent disability. We modify the Referee's 12 percent award accordingly.

Dermatitis Condition

Based on the opinion of Dr. Weiss, claimant's treating physician for her dermatitis, and based on claimant's testimony, the Referee found that claimant's dermatitis required continuous treatment and resulted in a moderate to severe limitation in many work-related activities. However, because claimant's treatment did not require "confinement at home," the Referee determined that claimant's impairment fell within Class 3 under former OAR 436-35-440 and awarded 38 percent unscheduled permanent disability. We agree that claimant's impairment should be rated as a Class 3 impairment, but for the following reasons.

Former OAR 436-35-440 provides that a Class 3 rating is appropriate where:

"Signs and symptoms of skin disorder are present; AND
"Continuous treatment is required; AND
There is moderate limitation in the performance of many work related activities."

Whereas a Class 4 rating is appropriate where:

Signs and symptoms of skin disorder are present; AND
"Continuous treatment is required, which may include periodic confinement at home or other domicile; AND
"There is moderate to severe limitation in the performance of many work related activities."

Drs. Perednia and Storrs, dermatologists, examined claimant on November 27, 1992. They felt that claimant had a primary irritant contact dermatitis and a contact urticaria (a vascular skin reaction) to latex. The doctors recommended that claimant: (1) reduce exposure to water, handwashing, and other similar irritants to a minimum; (2) use a steroid ointment as long as the dermatitis was present; and (3) avoid latex gloves. They concluded that if claimant could not sufficiently limit wet-work in her nursing work, then she may have to leave that type of employment. The doctors opined that claimant had a Class I dermatological impairment. Dr. Weiss concurred.

Dr. Weiss subsequently opined that claimant had a Class 4 impairment. He stated that Dr. Storrs' impairment rating concerned only the fingers, hands, and arms. Dr. Weiss explained that claimant's impairment is systemic and deals with the entire integumentary system. Dr. Weiss, therefore, concluded that it was more appropriate to classify claimant's impairment under the integumentary system. (Exs. 42, 43).

Claimant testified that she is still under continuous treatment, including avoiding latex, using prescription topical creams daily, and seeking medical treatment on an as needed basis. (Tr. 21, 35). Claimant last treated with Dr. Weiss in July 1992. At that time, Dr. Weiss reported that claimant was unable to perform her regular work in the ICU, but that she may be able to work on an infrequent or irregular basis. (Ex. 29). Claimant testified that she was unable to do general nursing duties at a hospital, a physician's office, an urgency care center, a skilled nursing center, or a medical clinic. (Tr. 23). Claimant is currently working as a research nurse.

Considering that claimant can control her current condition with medication and preventive measures and that she has been able to work, we conclude that claimant is moderately limited in performing many work related activities and that claimant's dermatitis condition constitutes a Class 3 impairment. See Sherry L. Low, 45 Van Natta 953 (1993).

Claimant's attorney is entitled to an attorney fee for services on review regarding the contact dermatitis issue. ORS 656.382(2). In determining a reasonable attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we conclude that a reasonable attorney fee for services on review concerning the extent of contact dermatitis permanent disability is $600, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 25, 1993 is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the Reconsideration Order award of 7 percent (22.4 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total award of 8 percent (25.6 degrees) unscheduled permanent disability for the low back. Claimant's counsel's out-of-compensation attorney fee from this award shall be adjusted accordingly. The remainder of the order is affirmed. For services on review regarding the extent of permanent disability for claimant's contact dermatitis, claimant's attorney is awarded $600, to be paid the the employer.

In the Matter of the Compensation of
RITA C. SHAMBOW, Claimant
WCB Case No. 91-09881
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband, and Neidig.

The SAIF Corporation requests review of Referee Galton's order that set aside its denial of claimant's occupational disease claim for a right wrist ganglion cyst and a worsened bilateral hand condition diagnosed as carpal tunnel syndrome (CTS). SAIF objects to the Referee's admission of post-hearing medical reports by Dr. Harris, treating orthopedist. On review, the issues are compensability and evidence. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has worked as a medical secretary/transcriptionist since 1955. She worked for SAIF's insured in that capacity from March 15, 1990 through February 15, 1991. At least half of her work involved repetitive hand and wrist motion, including typing.

Claimant has had bilateral hand complaints since 1981. These problems disappeared in 1985 and reappeared during the summer of 1990. She also had a preexisting right median wrist lesion, diagnosed as a ganglion cyst.

CONCLUSIONS OF LAW AND OPINION

Claimant's bilateral hand and right wrist problems preexisted her work exposure with SAIF's insured. There is no contention that claimant's current problems differ from her prior problems, except that they are worse. Under these circumstances, in order to prove entitlement to benefits for her hand and wrist conditions, claimant must establish that repetitive work activities with SAIF's insured were the major contributing cause of a worsening of the preexisting conditions. See ORS 656.802(1)&(2).

Considering the number of potential contributing causes for claimant's hand and wrist conditions, the causation issue is a complex medical question which must be resolved by medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993); Uris v. Compensation Department, 247 Or 420 (1967). We rely on those medical opinions which are well-reasoned and based on a complete and accurate history. 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 rely on the opinion of Dr. Long, treating electrodiagnostician, but not the opinion of Dr. Harris, treating orthopedist.

Claimant sought treatment from Dr. Long for hand and wrist complaints, beginning in 1983. Dr. Long's records reflect a complete and accurate history of claimant's symptoms and work activities. Based on claimant's history and his examination findings,[1] Dr. Long concluded that claimant's work activities were the major contributing cause of the worsening of her bilateral CTS condition which occurred between August 1990 and February 1991. (Ex. 51-2).

The medical evidence contrary to Dr. Long's opinion is provided by Drs. Nathan and Radecki. Dr. Radecki's conclusion that claimant's problems are not work-related is largely based on his belief that claimant does not have CTS. However, because claimant need not establish a specific or certain diagnosis in order to have a compensable claim, Dr. Radecki's opinion does not weigh against the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Robinson v. SAIF, 78 Or App 581 (1986). We note that Dr. Radecki also opined that a number of other causes may contribute to claimant's symptoms. However, because Dr. Radecki's opinion in this regard is either general (rather than specific as to claimant) or merely speculative, it is not particularly persuasive. See Sherman v. Western Employers Insurance, 87 Or App 602, 605 (1987); Gormley v. SAIF, 52 Or App 1055 (1981).

[1] Claimant performed no off-work activities involving repetitive hand-use. (See Tr. 65.)

In addition, we agree with the Referee that Dr. Nathan's opinion, which is based on a one-time examination of claimant, is less persuasive than Dr. Long's. In sum, we find no persuasive reason to discount the opinion of Dr. Long. See Weiland v. SAIF, supra; 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).

However, we do not rely on the opinion of Dr. Harris, treating orthopedist, even though Dr. Harris' ultimate conclusion is consistent with Dr. Long's.[2] Dr. Harris initially declined to comment on causation and recommended that a neurologist address that question. (Ex. 18). Thereafter, Dr. Harris summarily concurred with Dr. Radecki's May 13, 1991 report, indicating that claimant's hand complaints are "most likely" related to a longstanding problem (or may reflect off work stress), but are "not necessarily" due to typing at work. (See Exs. 24-3, 25). Finally, after the hearing, Dr. Harris opined that claimant's work as a transcriptionist did cause her carpal tunnel problems. (Exs. 56A, 58, 59). Because Dr. Harris failed to explain what caused his opinion to change significantly, we do not find his conclusions persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Nonetheless, we conclude that claimant's bilateral hand condition is compensable, based on Dr. Long's opinion.

SAIF argues that claimant's right wrist ganglion condition is not compensable, because the only medical opinion addressing its etiology is the opinion of Dr. Radecki and that opinion does not relate the right wrist condition to claimant's work activities. (See Ex. 57-47-48). We agree. Consequently, insofar as SAIF denied claimant's right wrist ganglion condition, the denial is upheld.[3]

Claimant is entitled to an assessed attorney fee for partially prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability of claimant's bilateral hand condition (diagnosed as CTS) is $700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 16, 1993 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial of claimant's right wrist ganglion condition is reversed. The denial of the ganglion condition is reinstated and upheld. The remainder of the order is affirmed. For services on review concerning the compensability of the bilateral CTS condition, claimant's counsel is awarded a $700 attorney fee, payable by SAIF.

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[2] We note SAIF's objection to the Referee's admission of Dr. Harris' post-hearing reports. (Exs. 56A, 58, 59). However, we do not rely on Dr. Harris' opinion because it is unpersuasive as we have explained. Therefore, even assuming that Dr. Harris' post-hearing reports should have been excluded, their admission resulted in no prejudice to SAIF. Consequently, we need not determine whether the Referee abused his discretion by admitting the disputed evidence.

[3] The dissent asserts that the Referee's attorney fee award should be reduced because claimant has not finally prevailed on her claim for a right wrist ganglion cyst. The dissent apparently assumes the Referee's attorney fee award is a "ceiling" which defines the limits of reasonable attorney fees. Theoretically, the Referee could have awarded the entire amount of attorney fees for claimant's bilateral hand condition, which we affirmed. On de novo review, we conclude, based on the factors set forth in OAR 438-15-010(4), that the Referee's attorney fee award is a reasonable fee for claimant's attorney's services at hearing regarding the bilateral hand condition issue.

Board Chair Neidig concurring in part and dissenting in part.

I concur with the majority's decision regarding the merits of these claims. However, I write to express my concern that the Referee's attorney fee should be reduced in this case, because claimant has not finally prevailed against SAIF's denial of the claim for a right wrist ganglion cyst. See ORS 656.386(1).

The Referee assessed a $2,950 attorney fee for counsel's services which resulted in the order setting aside SAIF's denials of the claims for a right wrist ganglion cyst and a worsened bilateral hand condition diagnosed as carpal tunnel syndrome (CTS). SAIF appealed the Referee's decision on the merits, but neither party objected to the amount of the fee assessed for prevailing on claimant's two claims.

On review, we uphold the Referee's decision concerning the CTS claim, but reinstate the denial of the right wrist ganglion cyst claim. Thus, claimant has not finally prevailed on her claim for a right wrist ganglion cyst and no fee for services associated with that claim is available under ORS 656.386(1). Nonetheless, even though the Referee's attorney fee assessment was based on prevailing on two claims and claimant has prevailed on only one (by virtue of our order), the majority leaves the Referee's $2,950 attorney fee undisturbed.

In my view, the majority's failure to reduce the Referee's attorney fee award (to reflect the fact that claimant has prevailed on only one claim) is contrary to ORS 656.386(1), longstanding Board policy, and the logical expectations of the parties. See Debra L. Cooksey, 44 Van Natta 2197, 2198 (1992) (citing Shoulders v. SAIF, 300 Or 606 (1986) for the proposition that no attorney fee is available under ORS 656.386(1) for two of claimant's conditions, because those two conditions were found to be not compensable); Edna M. Anderson, 44 Van Natta 2093, 2095 (1992) (Where we vacated a portion of a Referee's order finding proposed surgery reasonable and necessary, we also vacated a portion of the Referee's attorney fee); Robert L. Mowry, 43 Van Natta 1007, 1008 (1991) (Where the Referee's attorney fee was based on setting aside two separate denials of different conditions and we reversed the Referee's order regarding one of the denials, we also reduced the Referee's attorney fee accordingly).

Finally, I reiterate that neither party contested the amount of the fee assessed for prevailing on two conditions. Under these circumstances, by allowing that fee to stand even though claimant finally prevailed on only one condition, the majority effectively raises and decides an attorney fee issue on its own motion. In other words, if the $2,950 fee was appropriate (as it is unchallenged) for two conditions' compensability, how could the same fee be appropriate for only one condition's compensability? See Christopher C. Grayson, 45 Van Natta 2110 (1993) (ORS 656.386(1) "makes it clear that to be entitled to an assessed attorney fee, claimant must 'prevail' on a claim, that is, 'obtain' compensation."). As I see it, the Referee's attorney fee award must be reduced in order to be fair, consistent, and predictable. Accordingly, I respectfully dissent from the majority's decision not to modify that fee.

In the Matter of the Compensation of
KAREN S. BUNCE, Claimant
WCB Case No. 93-01161
ORDER ON REVIEW
David C. Force, Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Holtan's order which: (1) authorized recovery of an overpayment of temporary disability from permanent disability; (2) declined to direct the SAIF Corporation to pay claimant's scheduled permanent disability in a lump sum; and (3) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable claim processing. On review, the issues are offset, claim processing, penalties, and attorney fees.

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

Claimant contends that the Referee erred in approving SAIF's payment of scheduled permanent disability in monthly installments. We disagree.

On July 18, 1991, SAIF closed this claim by Notice of Closure, which included no award of permanent disability. Claimant requested reconsideration. On December 31, 1991, an Order on Reconsideration issued, awarding claimant 33 percent (105 degrees) unscheduled permanent disability. This award was stayed under ORS 656.313(1) pending SAIF's appeal of the award. At hearing, a referee affirmed the unscheduled award, but also granted an award of 5 percent (7.5 degrees) scheduled permanent disability.

Thereafter, combining both the unscheduled and scheduled awards, SAIF began paying the combined award in monthly installments. Claimant requested a hearing, contending that she was entitled to lump sum payment of her scheduled award.

The Referee concluded that the unscheduled and scheduled awards could be combined. Since the combination exceeded 64 degrees, the Referee found that payment of the combined award could be made in monthly installments. See ORS 656.230(2). The Referee reasoned that there was no distinction between the method of payment of unscheduled and scheduled permanent disability in ORS 656.216. The Referee further noted that both scheduled and unscheduled permanent disability are discussed generally in ORS 656.214.

ORS 656.230 provides:

> "(1) 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.
>
> "(2) In all cases where the award for permanent partial disability does not exceed 64 degrees, the insurer or the self-insured employer shall pay all of the award to the worker in one lump sum." (Emphases added).

The issue in this case is whether the unscheduled permanent disability awarded by the Order on Reconsideration and the scheduled permanent disability awarded by the prior referee are a single "award," or separate "awards," for purposes of ORS 656.230(2). In resolving that issue, we first examine the text and context of the statute.[1] See Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526, 533 (1993); Bartz v. State of Oregon, 314 Or 353, 357-58 (1992).

The text of ORS 656.230 provides some guidance as to the meaning of "award." In both subsections of ORS 656.230, "award" is used in reference to "permanent partial disability." There is no language either in ORS 656.230 or elsewhere in the statutes which distinguishes a scheduled "award" from an unscheduled "award" for purposes of making lump sum or installment payments. Finding no statutory basis for drawing such a distinction, we conclude that both scheduled and unscheduled permanent disability are included in the "award" for purposes of ORS 656.230. If the combined award is more than 64 degrees, the carrier may pay the combined award in installments, unless the Director orders otherwise.

Our conclusion in this regard is consistent with the court's interpretation of ORS 656.268(4)(g) in Nero v. City of Tualatin, 127 Or App 458 (1994). There, the court held that, in determining whether sufficient permanent disability compensation was awarded on reconsideration to require assessment of a penalty, in the absence of any qualifying words, the term "compensation" must be construed to refer to "the entire claim, including combined awards for scheduled and unscheduled disability." Id. at 463. Likewise, in the absence of any qualifying words in ORS 656.230, we also conclude that the term "award" must be construed to refer to the entire PPD award, including scheduled and unscheduled disability.

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[1] Our review of the legislative history for ORS 656.230 provided no useful guidance in determining the legislature's intent in using the term "award."

We likewise find no statutory basis for distinguishing, for purposes of ORS 656.230, permanent partial disability (PPD) awarded by an Order on Reconsideration from PPD subsequently awarded by a referee on appeal from the reconsideration order. The statutory scheme for claim closure and evaluation contemplates that any PPD awarded upon claim closure is subject to several possible levels of appeal: on reconsideration before the Department; at hearing before a referee; on Board review; and on judicial review. See ORS 656.268(4)(e), (5), (6)(b); ORS 656.289(3); ORS 656.295(8). Thus, if PPD is awarded upon claim closure, and the award is appealed and subsequently increased, we view the subsequent increase not as a separate "award" of PPD, but rather, as a modification of the original PPD "award."

Therefore, based on the text of ORS 656.230, particularly when viewed in the context of the statutory claim closure and evaluation provisions, we conclude that the term "award" in ORS 656.230 includes modifications made on appeal from the claim closure award. That is, there is one PPD award, if any, for each reopening of the claim.[2]

In this case, therefore, the prior referee's award of an additional 5 percent scheduled PPD is not a separate "award" under ORS 656.230, but rather, a modification of the original 33 percent unscheduled PPD awarded by the Order on Reconsideration. Hence, the "award" for purposes of ORS 656.230 is the combination of the 33 percent unscheduled PPD and the 5 percent scheduled PPD. Because the combination totals more than 64 degrees, SAIF properly began paying the award in installments pursuant to ORS 656.216.

Inasmuch as we conclude that SAIF properly paid claimant's PPD award in monthly installments, claimant is not entitled to either a penalty or carrier-paid attorney fee.

ORDER

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

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[2] This approach is not only supported by statute, but it is also the simplest for claim processing. For each reopening of a claim, claims examiners need only look to the total PPD awarded upon claim closure, as modified during any subsequent appeals, to determine the appropriate payment obligations under ORS 656.230 and ORS 656.216.

In the Matter of the Compensation of
RICHARD B. CAULKINS, Claimant
WCB Case No. 93-05435
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Mongrain's order which set aside its "de facto" denial of claimant's "new injury" claim for a cervical and thoracic condition. On review, the issues are compensability and claim processing. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

New Injury

Claimant compensably injured his cervical and thoracic spine in September 1989. In July 1992, while still working for the same employer, claimant was flipped into the air and landed in the area of his mid-back and shoulders. Claimant missed no time from work and did not seek treatment until September 1992, when he consulted a chiropractor, Dr. Hearns. Dr. Hearns diagnosed a cervical and dorsal strain with attendant myosistis and treated claimant until declaring him medically stationary in

In the Matter of the Compensation of
MARY K. TERCEK, Claimant
WCB Case No. 92-03297
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn, Westerband and Haynes.

The SAIF Corporation requests review of those portions of Referee Mills' order that: (1) set aside a Determination Order as prematurely issued; (2) set aside its aggravation denial; and (3) set aside its denial of claimant's current bilateral upper extremity condition. Claimant has moved to strike a portion of SAIF's reply brief. On review, the issues are motion to strike, aggravation, premature closure and compensability.

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

Claimant moves to strike that portion of SAIF's reply brief which addresses the aggravation issue. Claimant contends that SAIF failed to preserve that issue because it did not raise it in its appellant's brief. We deny the motion. The Board has de novo review authority and is free to make any disposition of the case it deems appropriate, including reaching issues that were before the Referee but not raised by the parties on review. See ORS 656.295(5); Destael v. Nicolai Co., 80 Or App 596 (1986); Neely v. SAIF, 43 Or App 319, 323 rev den 288 Or 493 (1979). Accordingly, inasmuch as the aggravation issue was raised before the Referee, we are free to address the aggravation issue regardless of whether it was raised in SAIF's appellant's brief. Thus, the motion to strike the portion of SAIF's reply brief which addresses the aggravation issue is denied. See Raymond B. Terrell, 45 Van Natta 2179 (1993).

Although we have denied claimant's motion to strike, we affirm the Referee's conclusions regarding the aggravation denial. By definition, an aggravation is a worsened condition occurring after claim closure. ORS 656.273. As the Referee observed, the alleged aggravation occurred prior to closure of the claim. Thus, there was no claim for aggravation to be denied.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for her counsel's services regarding the unsuccessful motion to strike.

ORDER

The Referee's order dated June 11, 1993 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

Board Member Haynes dissenting.

I disagree both that this claim was prematurely closed and that claimant has established that she has a compensable myofascial pain syndrome.

The persuasive medical evidence in existence at the time of closure supports a finding that no further material improvement was reasonably expected from medical treatment or the passage of time. Claimant's treating physician, Dr. Layman, found claimant medically stationary on August 7, 1990. Dr. Nye concurred with Dr. Layman that claimant was medically stationary on August 7, 1990. The claim was closed on March 10, 1992.

On April 20, 1992, Dr. Long opined that claimant was not medically stationary on the date of closure, because Dr. Johnson had reasonably expected material improvement from physical therapy at that time. The record does not support Dr. Long's belief that Dr. Johnson expected material improvement on the date of closure. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Dr. Johnson

began treating claimant just prior to closure. He prescribed physical therapy and treatment with DMSO. Johnson hoped that treatment with DMSO might benefit claimant since he explained that DMSO is occasionally of surprising benefit for people with perplexing and intractable musculoskeletal pain. A "hope" that treatment might prove beneficial is not a reasonable expectation of further material improvement. In addition, further testing and recommendations of physical therapy do not necessarily indicate that further improvement could have been reasonably expected at the time of closure. Teresa A. Forbes, 45 Van Natta 539, 540 (1993). There is no indication that, at the time of closure, Dr. Johnson expected the physical therapy to result in material improvement in claimant's condition. Accordingly, I would conclude that claimant has failed to establish that she was not medically stationary on the date of closure.

I would likewise conclude that the evidence preponderates against a conclusion that claimant has a compensable myofascial pain syndrome. Claimant was evaluated by numerous doctors. Only Dr. Long reached the diagnosis of myofascial pain syndrome. Most of the physicians who evaluated claimant ultimately concluded that claimant's condition was psychogenic in nature.

Claimant was first treated by Dr. Layman. Dr. Layman was "at a loss to explain the unusual etiology" of claimant's condition. Among other conditions, Dr. Layman investigated the possibility of an atypical myofascial syndrome, despite the fact that claimant did not have multiple trigger points. Dr. Layman referred claimant to a rheumatologist, Dr. Ingram. Dr. Ingram could not come up with a firm diagnosis for claimant's right arm pain, but felt that claimant's symptoms were work-related. Later, Dr. Ingram modified her opinion. She stated that if no organic basis had been found for claimant's pain, claimant's pain was possibly related to work conditions.

Dr. Nye also evaluated claimant. In February 1991, he stated in a chart note that he did not have a clue as to the etiology of claimant's symptoms. (Ex. 42A). He later said that he never found any objective evidence of abnormalities in her upper extremities and no real diagnosis was ever made. (Ex. 85).

Four other doctors concluded that claimant's pain was psychogenically based. Dr. Radecki, who had previously examined claimant on referral from Dr. Layman in 1990, opined that claimant had an idiopathic chronic pain syndrome relative to her upper extremities but no known medical disorder. (Ex. 73-3). He found no evidence of fibrositis, fibromyalgia or myofascial pain. Id. He felt that claimant's complaints are similar to those she had in 1989 and 1990, "vague, unsubstantiated" and psychogenically based. Dr. Radecki disagreed with Dr. Long (who found some median nerve slowing) and opined that claimant has no median nerve slowing and that her nerve conductions are the same as they were in 1990. (Ex. 73-4). Radecki felt that claimant's condition was not work-related since claimant had been doing minimal work and then was off work totally and still had the symptoms. Id.

Dr. Ochoa examined claimant for SAIF. He concluded that there was no evidence of organic neurological dysfunction. He opined that the nature of the symptoms, in conjunction with the normal neurological examination and normal tests, strongly suggested non-organic dysfunction by which the brain reads non-organic input as pain and dysesthesias. (Ex. 35-8). Ochoa recommended psychiatric evaluation. Ochoa agreed with Dr. Radecki's opinions. (Ex. 86-1). Ochoa opined:

> "In a patient like [claimant], who has vague complaints, has no suggestive signs on physical examination, and has no objective abnormalities in diagnostic tests, one either believes that psychological factors are involved in the generation of pain or that she is malingering. In her case, we believed that psychological factors were probably playing a major role in her complaints."

Dr. Parvaresh believed that claimant had a factitious disorder "whereby physical problems provide a way out of dealing with the more painful psychological problems." (Ex. 81-7). Parvaresh opined that claimant's underlying psychological problems are the major contributing cause of her nonorganic pain and discomfort. (Ex. 97-3).

Dr. Rosenbaum, neurologist, examined claimant on behalf of SAIF. He found no objective abnormality and agreed with Drs. Ochoa and Radecki that claimant's symptoms are psychogenic. (Ex. 92).

Of all the physicians who evaluated claimant, only Dr. Long diagnosed a myofascial pain syndrome, even though other specialists had been unable to find trigger points or other signs of the condition and had ruled it out. Moreover, the preponderance of the medical evidence indicates that claimant's condition is psychogenically based and is not related to her work. After reviewing this record, I conclude, based on the preponderance of the medical evidence, that claimant does not have a compensable myofascial pain syndrome. Accordingly, I must dissent.

In the Matter of the Compensation of
EUGENE D. VAUGHAN, Claimant
WCB Case No. 93-07916
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

The self-insured employer requests review of Referee Black's order which set aside its denial of claimant's occupational disease claim for carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities were the major contributing cause of his carpal tunnel syndrome (CTS). The employer argues that the Referee erred in concluding that claimant's diabetes, obesity and secondary hypertension were predisposing factors, rather than causes, of his CTS. We agree.

To prevail on his occupational disease claim, claimant must prove that his employment conditions were the major contributing cause of his CTS. See ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145 (1983).

In Liberty Northwest Ins. 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 cause a disease independently of 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).

The record contains opinions from two physicians regarding medical causation. Dr. Button, a hand and upper extremity specialist, concluded that claimant's work activities as a truck driver were not the major contributing cause of his need for treatment. Dr. Button stated:

> "There are several important pre-existing conditions commonly seen with carpal tunnel syndrome, that in and of themselves can be causative and those three have been listed above. The primary factors I feel relate to his body habitus with obesity, secondarily diabetes and hypertension, both under satisfactory control with medication." (Ex. 3).

Dr. Merrick concurred with Dr. Button "with the minor exception that [claimant] does correlate much of his symptoms with driving on the job. Therefore, whereas [claimant's] diabetes is definitely playing a role in his carpal tunnel syndrome, I think it is exacerbated by his job activities and therefore job-related." (Ex. 4). In a later opinion, Dr. Merrick stated:

> "It is true that carpal tunnel syndrome can be caused or aggravated by diabetes, as well as by work situations such as overuse. [Claimant] is a diabetic. However, his carpal tunnel symptoms all came on after driving a particular truck for Lane County. They resolved fairly rapidly when he stopped driving that truck and was put in a splint to immobilize the wrist. Based on this, I would conclude that his symptoms were primarily a result of his job stressors rather than the diabetes." (Ex. 8).

When there is a dispute between medical experts, we rely on those opinions that are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259, 263 (1986). Claimant argues that we should give greater weight to Dr. Merrick's opinion because he was the treating physician. However, we find that this case involves expert analysis rather than expert external observations, and therefore, the status of "treating physician" confers no special deference. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979).

Dr. Merrick noted that claimant's symptoms occurred when he was working and did "not occur at any other time; specifically not at nighttime." (Ex. 1A). On the other hand, Dr. Button correctly noted that claimant's symptoms occurred "occasionally at nighttime." (Ex. 3). Dr. Merrick's opinion appears to be based in substantial part on the mistaken impression that claimant had symptoms only at work. We discount Dr. Merrick's opinion because it is based on incomplete facts. See Somers v. SAIF, supra.

We give greater weight to Dr. Button's opinion because of his expertise as a hand and upper extremity specialist. See Abbott v. SAIF, 45 Or App 657, 661 (1980). We find Dr. Button's opinion to be better reasoned and based on complete information. Dr. Button concluded that claimant's diabetes, obesity and secondary hypertension were the "causative factors" in claimant's CTS. (Ex. 9). Claimant did not offer any persuasive evidence to rebut that opinion. The most that one can say for claimant is that the evidence is in equipoise. We conclude that claimant has not carried his burden of proving that his employment conditions were the major contributing cause of his CTS. See ORS 656.802(2); ORS 656.266.

ORDER

The Referee's order dated November 5, 1993 is reversed. The self-insured employer's denial is reinstated and upheld. The assessed attorney fee awarded by the Referee is also reversed.

Board Member Gunn dissenting.

Inasmuch as I am persuaded that claimant has established the compensability of his carpal tunnel syndrome claim, I respectfully dissent.

To begin, considering Dr. Merrick's familiarity with claimant's history of complaints and activities, I give his opinion as treating physician a great deal of weight. Moreover, Dr. Merrick's conclusion that claimant's symptoms were attributable to his work activities was further confirmed when those symptoms promptly subsided after claimant stopped his work activities and received "splint" treatments.

Dr. Merrick also shared Dr. Button's opinion that claimant's diabetes was playing a role in the carpal tunnel syndrome. However, unlike Dr. Button, Dr. Merrick did not consider the diabetes nor the other predispositions (obesity and hypertension) to be causative factors in claimant's carpal tunnel syndrome symptoms. I find Dr. Merrick's conclusion that claimant's work activities caused his symptoms to be compelling, particularly in light of Dr. Button's observation that claimant's other so-called "preexisting conditions" were under satisfactory control through medication.

In conclusion, I find no persuasive reason not to defer to the opinion expressed by Dr. Merrick, claimant's treating physician. Secondly, even if Dr. Merrick is not accorded deference as the treating doctor, I consider his observations and those of Dr. Button's to be sufficient to establish that claimant's work activities were the major contributing cause of his carpal tunnel syndrome. In this regard, I share the Referee's reasoning that claimant's diabetes, obesity, and hypertension were predispositions for, rather than causes of, claimant's carpal tunnel syndrome.

Based on the foregoing analysis, I would affirm the Referee's order which set aside the employer's denial of claimant's occupational disease claim.

In the Matter of the Compensation of
JAMES E. CORNELIOUS, Claimant
WCB Case No. 93-12444
ORDER OF DISMISSAL
Peter O. Hansen, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

The self-insured employer requested review of Referee Thye's order which: (1) held that claimant had timely appealed the employer's denial of his injury claim for a left foot cellulitis condition; and (2) set aside the employer's denial. The parties have submitted a proposed "Joint Petition and Order of Bona Fide Dispute Settlement" and "Addendum," which are designed to resolve all issues raised or raisable in this matter, in lieu of the Referee's order. Specifically, claimant agrees that the denial "will be reinstated and remain in full force and effect and the Opinion and Order of February 18, 1994 will be null and void in all respects."

We have approved the parties' agreement, thereby fully and finally resolving this dispute, in lieu of the Referee's order. In other words, the employer's denial is reinstated and upheld.

Finally, in granting this approval, we note that the agreement further stipulates that the "total" consideration of the settlement equals $3,538 ($2,038 of which represents "benefits already paid"). Based on this "total" consideration, the settlement further provides that claimant's attorney shall receive $884.50.

Inasmuch as the "benefits already paid" constitute compensation which has been paid pending review of the Referee's order, claimant is under no obligation to repay such compensation. See ORS 656.313(2). Since the employer has no lawful claim for the return of the $2,038 from claimant and because claimant has already received those funds, we do not consider such moneys to represent consideration for the settlement. Thus, the "total" consideration for the settlement equals $1,500. ($3,538 - $2,038).

Based on $1,500 in consideration, claimant's proposed attorney fee exceeds the schedule set forth in OAR 438-15-050. ($884.50 exceeds 25 percent of $1,500). However, after considering the complexity of the legal, factual, and medical issues (as represented by the record, the Referee's order, and as described in the settlement), as well as claimant's prior success at the hearings level in overturning the employer's denial, we are persuaded that such circumstances are extraordinary justifying the total attorney fee award granted under the settlement. See OAR 438-15-050.

Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELODY K. FALKENHAGEN, Claimant
WCB Case No. 93-07818
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Hazelett's order that: (1) upheld the self-insured employer's denial of claimant's left shoulder injury claim; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

While working one day in May 1993, claimant put some hand weights on a shelf shortly before her work shift ended. At 6:00 p.m., claimant left the store. At that time, she had no left shoulder pain. However, as the evening progressed, claimant noticed increasing pain in her left shoulder and eventually sought treatment. Claimant alleges that her activity in lifting the hand weights caused injury to her left shoulder.

The record contains two medical opinions regarding causation. Dr. Zivin, neurologist, examined claimant at the employer's request. Dr. Zivin diagnosed left shoulder tendonitis. (Ex. 15-5). He further stated that "spontaneous occurrence of tendonitis at the shoulders is quite common" and that there was "no specific injury * * * at the time of the barbell lifting." (Id. at 6).

Dr. Puziss, claimant's treating orthopedic surgeon, disagreed with Dr. Zivin's report, finding it "highly improbable that this injury is a spontaneous condition or idiopathic one given the timing of the injury and the fact that it happened on the job." (Ex. 16-1). He further indicated that, "on a more probable than not basis, [claimant's] shoulder injury is work related and is not spontaneous or idiopathic." (Id.)

Absent persuasive reasons, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Although Dr. Puziss rejected Dr. Zivin's opinion that claimant's injury was spontaneous, he provided no explanation for his conclusion that the shoulder condition was work-related despite the fact that claimant's symptoms began some time after she lifted the barbells, and she had previously performed such activity in the same manner numerous times without incident. Furthermore, we understand Dr. Puziss to attribute claimant's shoulder condition to work activity only because such activity could have caused the injury. Thus, his reasoning is speculative, and establishes nothing more than a possibility of a causal connection.

In summary, we find persuasive reasons not to defer to Dr. Puziss' opinion, and find it no more reliable than the opinion of Dr. Zivin. Consequently, we find that the medical opinions, at best, are in equipoise and conclude that claimant failed to carry her burden of proving the compensability of her left shoulder condition. See ORS 656.005(7)(a); ORS 656.266.

Inasmuch as claimant failed to prove compensability, there are no "amounts then due" upon which to warrant a penalty. See ORS 656.262(10); Wacker Siltronic Corp. v. Satcher, 91 Or App 654, 658 (1988).

ORDER

The Referee's order dated October 14, 1993 is affirmed.

Board Member Gunn dissenting.

I dissent. Our long-standing rule of law has been to defer to the treating physician's opinion absent a persuasive reason to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Although citing to this legal standard, the majority fails to follow it. Instead, it substitutes a standard requiring the treating doctor to report every factual detail and dispute every theory asserted by an independent medical examiner before finding the opinion reliable.

Here, there are no persuasive reasons for not deferring to Dr. Puziss' opinion since he shows an accurate understanding of the facts and offers a well-reasoned opinion. Consequently, under the correct legal standard for evaluating Dr. Puziss' opinion, it is entitled to deference. Since Dr. Puziss establishes that claimant's injury was caused by work activity, claimant proved compensability.

In the Matter of the Compensation of
TIMOTHY HASTY, Claimant
WCB Case No. 92-10763
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Schultz's order that: (1) set aside its denial of claimant's aggravation and current condition low back claims as procedurally invalid; (2) alternately, found claimant's aggravation and current condition claims compensable; and (3) found claimant's somatoform disorder compensable. On review, the issues are the validity of SAIF's aggravation and current condition denial, aggravation, and compensability. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for his first "Ultimate Finding of Fact," with the following clarification and supplementation.

Claimant's compensable condition became medically stationary on August 20, 1990. An October 17, 1990 Determination Order awarded claimant temporary but not permanent disability. A May 1, 1991 Order on Reconsideration found that claimant's claim was not prematurely closed, that claimant had no permanent impairment, and affirmed the Determination Order in all respects.

July 1990 x-rays of claimant's lumbar spine revealed degenerative disc disease.

Claimant requested a hearing concerning the October 1990 Determination Order, continuing to assert that his claim had been prematurely closed. Alternatively, claimant sought an award of permanent disability.

In June 1991, SAIF denied claimant's "condition diagnosed as a lower back and buttocks condition." At a September 1991 hearing, SAIF withdrew its June 1991 denial and agreed to accept the "injuries to claimant's low back, hips and left buttock as components of claimant's July 14, 1989 industrial injury[.]" Claimant no longer contended that his claim had been prematurely closed. Rather, he requested that prior Referee Peterson award him permanent disability for his low back impairment.

On November 1, 1991 (in accordance with the parties' agreement), Referee Peterson issued an order in which he found claimant's low back, bilateral hip, and left buttocks conditions to be components of the July 1989 compensable injury. Referee Peterson then rated claimant's permanent impairment, considering all compensable conditions. Finding that claimant had no permanent impairment as a result of the compensable injury, Referee Peterson affirmed the Order on Reconsideration (awarding no permanent disability).

CONCLUSIONS OF LAW AND OPINION

Aggravation

Finding that SAIF never processed claimant's low back and bilateral hip claim to closure, Referee Schultz reasoned that there could not be an aggravation of those conditions. Therefore, the Referee set aside SAIF's aggravation denial as procedurally defective. On review, SAIF argues that claimant's claim was closed by Determination Order in October 1990. Further, SAIF argues, the Determination Order was affirmed by the May 1991 Order on Reconsideration and October 1991 referee's order, in which Referee Peterson addressed and fully rated all of claimant's conditions, including the low back and hip conditions.

If at the time the aggravation claim was litigated, claimant's July 1989 injury claim remained open, there would be no last arrangement of compensation, and the aggravation issue would be nonexistent. Leslie G. Mullieux, 41 Van Natta 2068 (1989). On the facts of the instant case, however, we find that claimant's claim was properly processed to closure.

Claimant's claim was closed and fully rated by the October 1990 Determination Order, as affirmed by the May 1991 Order on Reconsideration. Referee Peterson considered claimant's low back, bilateral hip, and left buttocks conditions in a November 1991 order rating claimant's permanent impairment. We find, therefore, that SAIF's September 1992 aggravation denial was not procedurally defective. See Roseburg Forest Products v. Martin, 127 Or App 739 (1994) (where an employer had properly processed a claimant's claim to closure and all issues between the parties had been addressed, no further processing was deemed necessary). Having found SAIF's aggravation denial valid, we address the merits of claimant's aggravation claim.

Alternatively, the Referee found that claimant's compensable condition worsened. Specifically, the Referee found that claimant developed a debilitating somatoform pain disorder as a consequence of the work injury which rendered him less able to work as of February 1992. On review, SAIF argues that the parties agreed at hearing not to litigate SAIF's "de facto" denial of claimant's somatoform pain disorder at that time. Although claimant seeks affirmance of the Referee's order in its entirety, claimant does not challenge SAIF's representation. SAIF asserts, therefore, that it was inappropriate for the Referee to have considered the contribution of a condition that was not before him in determining whether claimant's compensable condition worsened. We agree, and consider only claimant's accepted right shoulder, low back, bilateral hip, bilateral leg, and left buttocks conditions.

After our de novo review of the record, we find, as did the Referee, that claimant's compensable low back condition worsened. We do so, however, based on the following reasoning.

In order to establish a compensable aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last award of compensation, he 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).

Claimant's claim was closed by Determination Order on October 17, 1990 (granting no award of permanent disability), as affirmed by Referee Peterson in November 1991. This was the last arrangement of compensation. Because there has not been an award of permanent disability, claimant is not required to prove that any worsening he experienced is more than waxing and waning of symptoms. Instead, he need only prove that his earning capacity is temporarily or permanently worse than it was in November 1991.

In February 1992, claimant began seeing Dr. Brack, who became his treating osteopathic physician for his low back condition. Dr. Brack opined that claimant has not sustained any specific worsening of his condition, other than increased pain. However, a pathological worsening is not required to establish an aggravation. A symptomatic worsening is sufficient, where 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. Lucas v. Clark, supra at 690; Smith v. SAIF, 302 Or App 396 (1986).

SAIF argues that there is no objective medical evidence in the record showing any worsening of claimant's condition since November 1991. Rather, it contends, Dr. Brack found only that claimant's pain had increased. Without objective medical evidence of a worsening, SAIF argues, claimant's subjective pain complaints are insufficient to prove an aggravation.

In November 1992, Dr. Brack opined that claimant had sustained a symptomatic worsening. He based his opinion on his examinations of claimant and various tests. Dr. Brack related claimant's low back pain complaints to his work-related injury, noted that claimant was not medically stationary, and restricted claimant from lifting more than 25 pounds.

Thus, Dr. Brack diagnosed a symptomatic worsening of the compensable condition based on expert analysis of his examination findings, test results, and claimant's reported symptoms. Such evidence meets the definition of "objective findings." See Georgia-Pacific v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1677 (1991). Such findings may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Stanley Smith Security v. Pace, 118 Or App 602, 605, rev den 317 Or 272 (1993).

Here, Dr. Brack did not simply recite claimant's pain complaints. Instead, Dr. Brack clearly evaluated claimant's symptoms over time and concluded that he had sustained a symptomatic worsening of his compensable condition. Therefore, we find that claimant has established a symptomatic worsening of his compensable condition (supported by objective findings) that resulted in diminished earning capacity. Accordingly, we affirm the Referee's alternate conclusion that claimant has established a compensable aggravation.

Compensability/Degenerative Disc Disease and Disc Herniation

Having found that SAIF never processed claimant's low back claim to closure, the Referee set aside SAIF's current condition denial as an impermissible pre-closure denial. However, as we have already found, claimant's claim was properly closed in October 1990. We do not agree, therefore, that SAIF's current condition denial constitutes an impermissible pre-closure denial.

Nonetheless, we agree with the Referee's further finding that by accepting claimant's low back "condition," SAIF necessarily accepted the degenerative disc disease and disc herniation which are inseparable from that condition. Accordingly, we adopt the Referee's reasoning and conclusion on this issue, with the following supplementation to address SAIF's arguments on review.

First, SAIF contends that although there was evidence in the record of mild degenerative disc disease at the time it accepted claimant's low back condition, SAIF never "expressly" accepted claimant's degenerative disc disease. Where a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988). When the acceptance does not identify the specific condition, we look to contemporaneous medical records to determine what condition was accepted. Cecilia A. Wahl, 44 Van Natta 25050 (1992).

In June 1991, SAIF denied claimant's "condition diagnosed as a lower back and buttocks condition." At the September 1991 hearing, SAIF withdrew its denial and agreed to accept the "injuries to claimant's low back, hips and left buttock as components of claimant's July 14, 1989 industrial injury[.]" SAIF did not identify the specific conditions it was accepting, and there are few medical reports in the record addressing claimant's low back condition prior to February 1992.

July 1990 x-rays revealed that claimant had lumbar spine degenerative disc disease. In May 1991, Dr. Dordevich, claimant's then attending physician, advised SAIF that claimant continued to experience severe lower back and buttock pain. In response, SAIF issued its June 1991 denial.

Based on this record, we conclude that claimant's current degenerative disc disease is the same condition he had at the time of SAIF's September 1991 acceptance when it accepted "injuries to claimant's low back, hips, and left buttock." Accordingly, we conclude that SAIF accepted claimant's low back condition, however it is diagnosed. Therefore, we agree with the Referee that SAIF's current condition denial of claimant's degenerative disc disease and disc herniation must be set aside.

In the event the Board finds that SAIF's current condition denial was procedurally proper, SAIF further argues that the Referee erred in relying on Dr. Dordevich's causation opinion (as concurred in by treating psychologist Fromm) over that of examining physician Adams. Although our holding that SAIF's current condition denial must be set aside is dispositive, were we to reach this issue, we too would rely on Drs. Dordevich and Fromm's opinion that claimant's degenerative disc disease and disc herniation were caused by the trauma of the July 1989 compensable injury. Therefore, under either analysis, we would set SAIF's denial aside.

Compensability/Somatoform Pain Disorder

As the parties agreed at hearing not to litigate SAIF's "de facto" denial of claimant's somatoform pain disorder at that time, this issue was not before the Referee. Consequently, we vacate that portion of the order that directed SAIF to accept and process claimant's somatoform pain disorder.

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

ORDER

The Referee's order dated September 22, 1993 is vacated in part and affirmed in part. That portion of the order that directed the SAIF Corporation to accept and process claimant's somatoform pain disorder is vacated. The remainder of the order is affirmed. For services on review concerning the aggravation and low back compensability issues, claimant is awarded an assessed attorney fee of $2,000, to be paid by SAIF.

In the Matter of the Compensation of
RONNIE J. KISTLER, Claimant
WCB Case No. 93-08429
ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys
Jim B. Thwing (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 26, 1994 Order on Review that affirmed a Referee's order setting aside its denial of claimant's aggravation claim for a cervical condition. After reviewing SAIF's motion and supporting memorandum, and claimant's response to SAIF's motion, we continue to adhere to our prior conclusion. However, we offer the following supplementation to our previous decision.

As a preliminary matter, SAIF contends that we failed to discuss claimant's alleged failure to attend appointments with his treating physician as the reason his claim was closed. Inasmuch as the issue for our resolution pertains to whether claimant's compensable condition has worsened since the last award or arrangement of compensation, the alleged basis for closure of the claim would appear to be of limited relevance. In any event, since this alleged reason for claim closure was not a primary factor in the medical reasoning which we found persuasive, we do not consider this alleged factor to be determinative.

SAIF further questions why we chose not to address two undisputed factual matters: (1) claimant's employment was terminated after he broke down a door; and (2) claimant was briefly employed moving heavy wood stoves during September 1992. None of the medical evidence implicates either of these two events in the worsening of claimant's cervical condition. Accordingly, we are not inclined to speculate as to the relevant contribution of those events.

Primarily, SAIF contends that we erred in finding the opinions of claimant's treating physicians more persuasive. We continue to agree with the Referee's findings that claimant's treating physicians (Drs. Amodt, Poul and Lee) are persuasive, both because we find their opinions to be well-reasoned and based on complete information, and because we find no persuasive reasons not to defer to their opinions as the treating physicians. See Weiland v. SAIF, 64 Or App 810 (1983).

SAIF argues that the medical evidence provided by claimant's treating physicians is not "credible." SAIF contends that the medical reports of Drs. Amodt and Poul reveal their bias against medical doctors. We disagree.

Drs. Amodt and Poul are no less persuasive simply because they disagree with the medical opinions of Drs. Wilson and Duff, who examined claimant at the request of SAIF. Drs. Amodt and Poul stated their concerns that claimant did not receive the care necessary immediately following his

compensable injury of March 16, 1992. (Ex. 12). Following a thorough and well-documented examination, Dr. Poul concluded that claimant would respond favorably to curative chiropractic treatment. (Ex. 13). While their reports reflect dissatisfaction with claimant's earlier medical care, as well as with SAIF's alleged reluctance to recognize a compensable aggravation, such frustrations do not cause us to reject their opinions regarding the relationship between claimant's compensable injury and his current condition.

Furthermore, SAIF argues that Dr. Lee is not persuasive because his medical opinion was allegedly prepared in anticipation of litigation. In the absence of specific evidence impeaching the reliability of this medical opinion, we find no reason to reject Dr. Lee's observations. We also disagree with SAIF's contention that Dr. Lee's diagnosis does not comport with the conclusions of Drs. Amodt and Lee. Dr. Lee found the presence of active trigger points in the muscle groups in the shoulder/neck area of the right side, (Ex. 21-2), while Drs. Amodt and Poul found similar evidence of muscular tension, stiffness and upper back pain, and persistent cervical and thoracic trigger points. (Ex. 13-4).

SAIF also contends that the testimony of Dr. Wilson is more persuasive. Dr. Wilson testified at hearing that he found no evidence of a cervical strain. However, Dr. Wilson did confirm Dr. Lee's finding inasmuch as Dr. Wilson noted the presence of active trigger points in the "right suboccipital". (Tr. 40). In any event, Dr. Wilson's testimony does not cause us to reject the persuasive opinions of Drs. Amodt, Poul and Lee.

Finally, we find that the medical opinions establish that claimant suffered diminished earning capacity as a result of his worsened condition. In addition to Dr. Lee's opinion that the job of a "talk show host" would be appropriate for claimant's worsened physical condition, (Ex. 21-2), Dr. Poul's work restrictions of August 8, 1993 demonstrate that claimant was less able to do work. (Ex. 19).

Based on the reasoning expressed above, as well as for the reasons expressed in the Referee's decision and our prior order, we find that the opinions of Drs. Amodt, Poul and Lee satisfied the statutory requirements for establishing a compensable aggravation claim.

Claimant is also entitled to an additional assessed attorney fee for his counsel's services on reconsideration. 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 concerning SAIF's request for reconsideration is $300, 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 response to SAIF's request for reconsideration), the complexity of the issues, and the value of the interest involved.

Accordingly, our May 26, 1994 order is withdrawn. On reconsideration, we adhere to and republish our May 24, 1994 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

Defense counsel notes in the conclusion portion of his request for reconsideration comments made by two members of the five-member Workers' Compensation Board.

On June 3, 1994, it should be noted that both members prefaced their comments with the disclaimer that these were their views and comments were not discussed or approved by any other Board members.

The defense goes on to state a presumption that the "professionalism" stated by the Board members will extend to the quality of review by the Board members.

I wish to assure counsel that all exhibits, transcripts and briefs were carefully reviewed this time and before, during the original Order on Review. The fact that counsel did not get the answer they wish is not because we didn't review the record but because we had.

In the Matter of the Compensation of
TERRY C. KNOWLES, Claimant
WCB Case No. 93-06375
ORDER ON REVIEW
Parker, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

The SAIF Corporation requests review of that portion of Referee Mills' 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 of fact; however we do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established a compensable aggravation claim. On review, SAIF contends that claimant has failed to establish that his current condition is causally related to the July 15, 1991 compensable injury. In addition, SAIF contends that claimant has failed to establish that his condition has worsened.

An aggravation claim has two components: causation and worsening. Both components must be established in order for the claim to be compensable. If the current condition is compensable, we then determine whether the compensable condition has worsened since the last arrangement of compensation. See Gray v. SAIF, 121 Or App 217 (1993); Dotty C. Fowler, 45 Van Natta 1649, 1650 (1993).

Here, there is no contention that claimant's current condition is a secondary consequence of the compensable injury or is the result of a preexisting condition. Accordingly, claimant need only establish that the 1991 injury is a material contributing cause of his current low back condition.

After reviewing the medical evidence, we conclude that claimant has failed to establish that the 1991 compensable injury is a material contributing cause of his current low back condition. Two medical opinions address the cause of claimant's current low back condition. Drs. Tesar and Wilson examined claimant on behalf of SAIF. They concluded that claimant had no abnormal objective findings. They noted decreased range of motion, but believed that these findings were not totally objective. They found inconsistencies both in history and on physical examination. Noting that claimant had had no significant medical treatment in a year and a half except for visiting his wife's doctor, Tesar and Wilson opined that claimant's condition had not objectively worsened. The physicians further opined that the July 15, 1991 compensable injury was no longer contributing to claimant's disability or need for treatment.

Dr. Jensen treated claimant for the 1991 compensable injury and for the alleged aggravation. Dr. Jensen initially opined that claimant's condition appeared to be an aggravation of the 1991 injury, and did not appear, by claimant's report, to be a new injury. However, at her deposition, Dr. Jensen explained that claimant had new findings on examination which he did not have in 1991. Specifically, these new findings involved the pelvic and hip muscles. Dr. Jensen testified that claimant still had left lower back pain as he did in 1991, but that most of claimant's findings in 1993 involved the pelvic and hip muscles. Thus, Dr. Jensen was unable to determine the percentage of contribution of the 1991 injury to claimant's current low back condition.

In addition, Dr. Jensen could not make a direct correlation between the 1991 injury and the new findings. Dr. Jensen noted that claimant's subjective reporting indicated that the 1991 injury was a major factor in his 1993 pain. However, Dr. Jensen was not able to make such a connection based on her own examination findings. (Ex. 25-15). Dr. Jensen noted that it was possible that the 1991 injury could predispose adjacent areas of the body to injury. However, Dr. Jensen was unable to rule out other possible causes for claimant's condition.

After reviewing Dr. Jensen's reports and deposition, we are not persuaded that her opinion establishes, to a reasonable medical probability, that the 1991 compensable injury was a material contributing cause of claimant's current condition.

Based on this record, we are unable to conclude that the 1991 compensable injury was a material contributing cause of claimant's current low back condition. Accordingly, we conclude that SAIF's aggravation denial should be upheld. Having found claimant's current condition not compensable, we need not address whether this condition has worsened. See Gray v. SAIF, supra.

ORDER

The Referee's order dated September 28, 1993 is reversed. SAIF's aggravation denial is reinstated and upheld. The Referee's award of a $2,500 assessed attorney is also reversed.

Board Member Hall dissenting.

This is a case in which the opinion of the treating doctor is entitled to deference. Dr. Jensen treated claimant for his original injury and for the claimed aggravation/current condition. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case there are no persuasive reasons to reject the treating doctor's opinion.

The majority faults Dr. Jensen for not making a "direct correlation" between claimant's current condition and the original injury and because Dr. Jensen was unable to determine "the percentage" of contribution from the original injury. The legal test, however, is whether, based upon the evidence as a whole, there is a material relationship between the original injury and claimant's current condition and aggravation. Whether the requisite relationship exists is a question of fact and law for the Board to decide, based upon medical information and explanation. We should not look to medical witnesses to provide legal conclusions.

Based upon the medical explanations and opinions of claimant's treating doctor, I find the preponderance of medical evidence supports a determination that claimant's current condition is materially related to his original compensable condition. Therefore, I respectfully dissent.

In the Matter of the Compensation of
VIRGINIA M. LEWIS, Claimant
WCB Case No. 93-03617
ORDER ON REVIEW
Max Rae, Claimant Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of Referee Garaventa's order that affirmed the Department of Consumer and Business Services' order which found that claimant was a non-subject worker. On review, the issue is subjectivity.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated September 24, 1993, as reconsidered October 20, 1993, is affirmed.

Board Member Gunn dissenting.

The majority concludes that, pursuant to ORS 656.027(18), claimant is a non-subject worker. Because I do not believe that provision is applicable to this worker, I dissent.

In 1991, the Legislature added subsection 18 to ORS 656.027. That provision provides that a "person performing foster parent or adult foster care duties" is a nonsubject worker and therefore not covered by ORS Chapter 656. The subsection was evidently adopted in reaction to a prior Board decision which held that a foster parent was a subject worker. See Yvette R. Oglesby, 42 Van Natta 2807 (1990). Several reasons were given for creating the exclusion, including the fact that foster parents are not required to pay income tax on monies received for providing care and are not considered employees for purposes of unemployment compensation. However, the major reason was that the cost of providing workers' compensation insurance would force a number of foster care providers out of business. See (Testimony of Dexter Henderson, Contacts Manager and Provider Relations Supervisor for Senior and Disabled Services Division, Oregon House Labor Committee, Hearings on HB 2474, March 18, 1991, Tape 65 at 339-370).

In the present case, claimant was employed, for pay, by a business that operated three adult foster homes. It is a for-profit business and not the type that was meant to be covered by the exemption in ORS 656.027(18). In light of this, I agree with claimant that commercial, for-profit, foster care providers should not be covered by this subsection. I would find that claimant is a subject worker and therefore entitled to workers' compensation benefits.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
LONNIE F. SCHELLER, Claimant
WCB Case No. 92-00964
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Robert Jackson (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Scheller v. Holly House, 125 Or App 454 (1993). The court has reversed our prior order which held that two "post-reconsideration order" medical reports from claimant's attending physician were not admissible. Noting that no medical arbiter had been appointed, the court reasoned that the evidentiary limitation of ORS 656.268(7) was not applicable. Concluding that ORS 656.283(7) was applicable and contained no such limitation, the court has remanded for reconsideration in light of the previously excluded medical reports.

On reconsideration, we adopt and affirm the order of the Referee with the following supplementation.

The Referee awarded 5 percent scheduled permanent disability for loss of use or function of the right knee, whereas an Order on Reconsideration had not awarded permanent disability. In reaching this conclusion, the Referee had relied on "post-reconsideration order" medical reports from Dr. Mayhall, claimant's attending physician, which supported a "chronic condition" award.

On review, we concluded that neither "post-reconsideration order" medical report was admissible. Inasmuch as those excluded reports were the basis for claimant's permanent disability award, we held that claimant was not entitled to such an award. Consequently, we reversed the Referee's order.

The court has reversed our decision. Scheller v. Holly House, supra. Reasoning that the "post-reconsideration order" medical reports are admissible, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

In order to be entitled to scheduled chronic condition impairment, the medical evidence must establish that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. OAR 436-35-320(5). We have interpreted this rule as requiring medical evidence of at least a partial loss of ability to repetitively use a body part. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452, 1453 (1993).

Here, when asked to give an opinion concerning a chronic condition, Dr. Mayhall, claimant's treating physician, noted that claimant was able to perform her work-at-injury as a waitress, but could not tolerate a job where she had to deal with heavy lifting or moving of furniture. (Ex. 14-1, 14-2). Dr. Mayhall stated that claimant's knee injury would make her less likely to be able to do lifting, twisting and moving of furniture to set up banquets. Thus, it was his opinion that claimant had impairment of her knee (Ex. 15), and probably had a chronic condition that "limits her ability to lift, move furniture, etc." (Ex. 14-2).

SAIF argues that, because Dr. Mayhall opined that some of claimant's inability to use her knee to lift and move furniture may be preexisting, his reports do not establish to what extent claimant's chronic condition was caused by her accepted right knee condition. We do not find this argument persuasive. Notwithstanding this reference to a preexisting condition, Dr. Mayhall continued to opine that claimant had restrictions as a result of damage to the articular cartilage of her knee which was referrable to her knee injury. (Ex. 15). Accordingly, we agree with the Referee that Dr. Mayhall's report does support a conclusion that claimant is entitled to a chronic condition impairment as a result of her compensable right knee injury.

Finally, claimant is entitled to a reasonable attorney fee award before every prior forum for finally prevailing on the extent of scheduled permanent disability issue. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review and before the court concerning the extent of scheduled permanent disability issue is $3,000, to be paid by the SAIF Corporation.[1] 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 issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, the Referee's order dated July 22, 1992 is affirmed.

IT IS SO ORDERED.

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[1] By this order, we also affirm the Referee's award of an "out-of-compensation" attorney fee equal to 25 percent of claimant's increased permanent disability, not to exceed $2,800.

In the Matter of the Compensation of
DELORIS K. FROST, Claimant
WCB Case No. 93-10624
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Black's order which assessed a penalty under ORS 656.268(4)(g) equal to 25 percent of all compensation due under an Order on Reconsideration. On review, the issue is penalties.

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

An Order on Reconsideration increased claimant's scheduled permanent disability award for the right leg from 6 percent (9 degrees), as awarded by a Notice of Closure, to 24 percent (36 degrees). The Department, however, did not assess a penalty in its Order on Reconsideration. Claimant requested a hearing. Reasoning that claimant was entitled to a penalty under ORS 656.268(4)(g),[1] the Referee assessed a penalty based on the increased compensation awarded by the Order on Reconsideration.

SAIF contends that a penalty is contrary to the Director's rule, OAR 436-30-050(13), which provides for a penalty only when claimant's total disability, whether scheduled, unscheduled or combined, equals at least 64 degrees. Because claimant's scheduled disability equals only 36 degrees, SAIF contends that she is not entitled to a penalty. We disagree.

Subsequent to the Referee's order, the Court of Appeals reversed our order in Jay A. Nero, 45 Van Natta 1082, 1084 (1993), in which we held that claimant was not entitled to a penalty under ORS 656.268(4)(g) when an Order on Reconsideration granted 12 percent unscheduled and 11 percent scheduled permanent disability. Nero v. City of Tualatin, 127 Or App 458 (1994). Although the combined awards exceeded the 20 percent minimum permanent disability required by the statute for a penalty, we reasoned that the statute was ambiguous and the legislative history unhelpful regarding whether scheduled and unscheduled awards may be combined to reach the 20 percent disability threshold. Therefore, we relied on the Director's rule, OAR 436-30-050(13), which allows a penalty under ORS 656.268(4)(g) when the combined award totals at least 64 degrees. Because claimant's combined award did not satisfy the "64 degrees" requirement of the Director's rule, we declined to assess a penalty.

The court reversed, stating it perceived no ambiguity in the language of ORS 656.262(4)(g). Inasmuch as the statute mandates that the amount of the penalty be based on "all compensation determined to be then due to claimant," the court concluded that the legislature, in setting a "20 percent" permanent disability threshold, intended to refer to the entire claim, including combined awards for scheduled and unscheduled permanent disability.

We find that the court's reasoning applies as well in the present case, where an Order on Reconsideration granted claimant 24 percent scheduled permanent disability. Claimant is entitled to a penalty by the plain terms of the statute, because on reconsideration she received at least 20 percent permanent disability, as well as a 25 percent increase over the 6 percent amount awarded by Notice of Closure. ORS 656.268(4)(g). The plain terms of the statute provide no basis for requiring a scheduled award to equal at least 64 degrees, rather than "20 percent" permanent disability, before a penalty can be assessed under ORS 656.268(4)(g).

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[1] ORS 656.268(4)(g) provides:

"If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

Moreover, we have previously held that the Department properly assessed a penalty under ORS 656.268(4)(g) when it awarded 23 percent (34.5 degrees) scheduled permanent disability. Vernal M. Davidson, 46 Van Natta 704 (1994). In doing so, we declined to interpret OAR 436-30-050(13) as a bar to the assessment of a penalty pursuant to the terms of ORS 656.268(4)(g). Id., citing Steven L. Cline, 46 Van Natta 132, on recon 46 Van Natta 512, n.1 (1994). We decline to do so here as well.

SAIF next contends that, based on our reasoning in Vena K. Mast, 46 Van Natta 34 (1994), the Referee lacked jurisdiction to assess a penalty under ORS 656.268(4)(g). However, in Steven L. Cline, supra, we disavowed that portion of our decision in Mast in which we stated that the Board and its Hearings Division "lack authority to assess a penalty under ORS 656.268(4)(g)," recognizing that statement to be an impermissible restriction on the statute. We concluded that when the requirements for a penalty under ORS 656.268(4)(g) have been met, the Board and its Hearings Division are authorized to assess the penalty, if the Department fails to do so. See also David J. Bunk, 46 Van Natta 836 (1994).

Claimant seeks an attorney fee for her counsel's services on review. The sole issue on review was claimant's entitlement to a penalty. However, no attorney fee is available under ORS 656.382(2) for successfully defending a penalty award. Saxton v. SAIF, 80 Or App 631 (1986). Therefore, we do not award an attorney fee.

ORDER

The Referee's order dated January 21, 1994 is affirmed.

June 23, 1994 Cite as 46 Van Natta 1219 (1994)

In the Matter of the Compensation of
PENNY L. GOURDE, Claimant
WCB Case No. 93-07363
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Lipton's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral hand condition; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that her bilateral carpal tunnel syndrome was caused by her keyboard activities performed at work. We agree with the Referee that claimant failed to carry her burden of proving that work activities were the major contributing cause of her condition. See ORS 656.802(2).

The record contains three opinions regarding causation. Claimant's treating physician, Dr. Nicholson, family practitioner, indicated that claimant's repetitive job activities could cause carpal tunnel syndrome. (Exs. 9A, 15). We agree with the Referee that, inasmuch as Dr. Nicholson supported only a possible, rather than probable, causal relationship, his opinion is not reliable. Gormley v. SAIF, 52 Or App 1055 (1981).

Dr. Radecki, electodiagnostic specialist, evaluated claimant on behalf of SAIF. Dr. Radecki found that claimant's condition was not work-related, instead attributing it to aging, the possible onset of menopause, an overweight condition, and increased wrist squareness. (Ex. 7-3).

Finally, Dr. Nye, hand surgeon, examined claimant at SAIF's request. Based on a history that claimant performed between three to six hours of word processing a day, Dr. Nye indicated that claimant's work activities were the major contributing cause of her condition. (Exs. 10-2, 12, 13). However, he also indicated that if claimant actually performed a nominal amount of word processing, such as an hour per work day, her condition would be idiopathic. (Ex. 13).

We disagree with the Referee's finding that Dr. Nye relied upon an inaccurate history. According to the Referee, Dr. Nye understood that claimant continuously performed word processing when, in fact, her typing was sporadic throughout the work day. Nothing in Dr. Nye's reports reflects a history that claimant continuously typed. More importantly, his opinion was based on the amount of time performing word processing rather than its continuous or sporadic nature. Inasmuch as Dr. Nye's history corresponds with claimant's credible testimony that she performed an average of five hours per day typing, we find that it is based on an accurate history.

Moreover, we find no substance to Dr. Nye's assertion that Dr. Radecki's opinion was based on an inaccurate history of claimant's weight loss and Dr. Radecki's "closely held feelings." Dr. Radecki correctly understood that claimant's weight loss was 30 pounds and provided survey results supporting his opinion linking obesity and menopause to carpal tunnel syndrome. (Ex. 14).

Thus, we find that the opinions of Dr. Radecki and Nye are based on an accurate history and equally well-reasoned. Furthermore, because both physicians examined claimant on behalf of SAIF, neither is entitled deference as a treating physician. Consequently, we find that the opinions of Dr. Radecki and Dr. Nye are equally persuasive. Having found both opinions reliable, we conclude that the medical evidence is in equipoise and claimant failed to carry her burden of proof. See ORS 656.802(2).

ORDER

The Referee's order dated October 5, 1993 is affirmed.

June 23, 1994 Cite as 46 Van Natta 1220 (1994)

In the Matter of the Compensation of
CARROLL G. JOHNSON, Claimant
WCB Case No. 92-14558
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Yturri, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Menashe's order which upheld the insurer's denial of his occupational disease claim for a psychological condition and peptic ulcer disease. In his brief, claimant contends that the Referee erred by striking a portion of Exhibit 27 from the record. On review, the issues are compensability and evidence.

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

We do not adopt the Referee's conclusion that claimant's termination in September 1991 was not unreasonable disciplinary action. (Opinion at 5). Nonetheless, we agree with the Referee that claimant has not carried his burden of proof.

Claimant's termination in September 1991 was not, on this record, claimed to be the primary reason for claimant's mental disorder. Rather, it was one occurrence (albeit a serious one) in a series of events and contacts beginning in 1990 when claimant began working as an Assistant Peeler. Claimant contends that his work was stressful from the outset, and he blames his coworkers and supervisors for his difficulties.

It is apparent that claimant has preexisting problems. He characteristically does not admit to them. For the reasons stated by the Referee, it is, for the most part, difficult to equate the reality with claimant's perception of the events. Only Dr. Turco has taken the serious non-work stressors and claimant's preexisting problems into account in rendering his opinion on causation. His opinion is the most persuasive and, thus, we agree with the Referee that claimant has failed to carry his burden of proof.

In his brief, claimant contends that Exhibit 27, a report from Mr. White, should have been admitted in its entirety. The Referee omitted an opinion expressed by Mr. White concerning the attitude of an employee to whom Mr. White spoke. Mr. White commented that the attitude of the employee "gave me cause to believe that any person making a claim at [the employer] could possibly be subjected to excessive stress." Claimant argued that the statement is indicative of the attitude of the employer concerning workers' compensation claims that are filed there.

After our de novo review of the record, including the context of the omitted statement, we conclude that, even if the statement had been admitted into evidence, it would not be sufficient to carry claimant's burden of proving that his work activities are the major contributing cause of his psychological condition and peptic ulcer disease. In light of such circumstances, we decline to consider claimant's contention that the Referee erred in excluding Mr. White's report.

ORDER

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

June 23, 1994 Cite as 46 Van Natta 1221 (1994)

In the Matter of the Compensation of
WARREN E. KEMERY, Claimant
WCB Case No. 92-13322
ORDER ON REVIEW (REMANDING)
Ralph M. Yenne, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Howell's order upholding the SAIF Corporation's denial, on behalf of the Department of General Services/Inmate Injury Fund, of claimant's claim for a left finger injury. On review, the issue is timeliness of the claim, including whether the Board has authority to review the Department's decision not to process the claim. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

This is a review of an inmate injury claim under ORS 655.505 to 655.550. Claimant amputated his left ring finger on November 4, 1991, while performing "authorized employment" as defined in ORS 655.505(1). On behalf of the Department of General Services/Inmate Injury Fund (Department), the SAIF Corporation denied the claim because it was not filed with the Department within 90 days after the injury, as required under ORS 655.520(3). That provision provides as follows:

> "The rights to benefits under ORS 655.505 to 655.550 shall be barred unless written claim is filed with [the Department of General Services] within 90 days after the injury . . . . The requirements of this subsection may be waived by the department on the ground that, for good and sufficient reason, the claim could not be filed on time."

Here, pursuant to established Correction Division procedures for filing injury claims, claimant submitted a timely written injury claim to his supervisor on January 10, 1992. However, the supervisor did not forward the claim to the Department until July 8, 1992, after the expiration of the 90-day filing deadline.

SAIF denied the claim because it was not received by the Department within 90 days of the injury. The Department declined to exercise its discretion under ORS 655.520(3) to waive the filing deadline in this case, and claimant requested a hearing on that decision.

The Referee concluded that the Hearings Division had no authority to review the Department's action in this matter. The Referee reasoned that ORS 655.520(3) gives exclusive authority to the Department to determine if "good and sufficient reason" exists to waive the filing requirements of that provision. This issue has never been directly addressed by the court or the Board.

In Dept. of Justice v. Bryant, 101 Or App 226 (1990), the court concluded that the Board did not have de novo review authority over a decision by the Department of Justice (DOJ) that an inmate did not show "good and sufficient reason" for failing to timely file a claim. Id. at 229. The court went on to conclude that the Department's decision did not represent an abuse of DOJ's discretionary authority in this matter. Id. at 229-230. However, the court assumed without actually deciding that such "abuse of discretion" review authority existed. Id.

In Kenneth G. Riley, 43 Van Natta 1380 (1991), the Board declined to assess a penalty and fee for late acceptance of an inmate injury claim because DOJ was not legally obligated to accept the claim. In reaching its decision, the Board concluded that a timely written claim had not been filed with DOJ, and that claimant had not shown good and sufficient reason for the late filing. Id. at 1381. Thus, the Riley Board implicitly concluded that, for the purpose of resolving a penalty and fee dispute, it had the authority to determine whether a claimant had good and sufficient reason for late filing within the meaning of ORS 655.520(3). However, the Board did not determine whether it had authority to actually reverse a DOJ decision not to waive the filing requirement under an abuse of discretion standard.

In William A. Stevenson, 44 Van Natta 96 (1992), the Board reasoned that an inmate injury claim was time-barred because DOJ had not waived the statutory filing requirement. However, it is not clear from the decision whether the Board was concluding that it had no authority to review DOJ's decision, or whether it was assuming such authority and finding no abuse of discretion on the record before it.

Similarly, in Michael Ivanov, 45 Van Natta 2352 (1993), the Board assumed without deciding that it had review authority, and it concluded that there was no abuse of discretion in DOJ's application of its written policy regarding waiver of the statutory filing requirement. Finally, in Marvin Grove, 46 Van Natta 154 (1994), a majority of the Board adopted without discussion a referee order finding an inmate injury claim time-barred under circumstances virtually identical to those in the present claim. Again, the basis for the Board's decision was unclear.[1]

In summary, we are aware of no Board or court opinion squarely addressing the Board's authority to review an agency decision not to waive the filing requirements for an inmate injury claim. This is, therefore, a question of first impression for the Board.

We begin our analysis with the Referee's determination that ORS 655.520(3) gives exclusive authority to the Department to determine if "good and sufficient reason" exists to waive the statutory filing requirement. In interpreting statutes, the Board looks first at the statutory text to discern the intent of the legislature. ORS 174.020; S-W Floor Cover Shop v. National Council on Compensation Insurance, 318 Or 614 (1994). The language of the provision should be read in the context of other provisions of the same statute. Id. If there is no ambiguity, the plain language of the statute controls. Id.

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[1] In a dissenting opinion, Board Member Hall concluded that the claim was timely filed in accordance with ORS 655.520(3). Alternatively, the dissent concluded that the Department abused its discretion in declining to waive the filing requirement in this case. The dissent reasoned that ORS 655.525 authorized the Board to review the Department's waiver decision for abuse of discretion.

Here, ORS 655.520(3) is silent as to the finality or reviewability of a Department decision not to waive the statutory filing requirements. We must, therefore, read this provision in conjunction with ORS 655.525, which authorizes Board review of inmate injury claims. The latter provision reads in pertinent part:

> "An inmate . . . may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304."

Pursuant to this section, the Board routinely reviews denials of inmate injury claims issued by SAIF on behalf of the Department. However, ORS 655.525 does not limit the Board's review authority to such decisions on the merits. Nor does the provision expressly except from the Board's review authority Department decisions not to waive filing requirements. Rather, the statute gives the Board broad review authority over "action taken on the claim."

Given this broad and unambiguous language, we conclude that the legislature intended for the Board to have review authority over any and all actions taken on an inmate injury claim. This includes the Department's exercise of its discretionary authority to waive the 90-day filing requirement.

Accordingly, we must determine whether the Department abused its discretion in not waiving the filing requirement in this case. Dept. of Justice v. Bryant, supra 101 Or App at 230 (assuming Department decision not to waive filing requirement is reviewable, proper review standard is abuse of discretion).

The Referee made an alternative ruling that the Department's decision was not an abuse of discretion. However, the record developed at hearing is devoid of any evidence regarding the basis for the Department's decision not to waive the filing deadline. In particular, there is no evidence of any established policy that the Department might have relied on in reaching its decision. Without any evidence of the reason for the Department's action, we are unable to determine whether it abused its discretion in this matter. Compare Dept. of Justice v. Bryant, supra, 101 Or App at 229-230 (no abuse of discretion where Department decision not to waive filing requirement is consistent with written Department policy).

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

For the reasons given above, we conclude that the record in this case is incompletely developed, and that there is a compelling reason to remand. Accordingly, we remand this matter to Referee Howell for further proceedings consistent with this order. At those proceedings, the Referee shall take additional evidence regarding the basis for the Department's decision not to waive the 90-day filing requirement in this claim. The Referee shall then issue a final order reviewing the Department's action for abuse of discretion.

ORDER

The Referee's order dated May 21, 1993 is vacated. This matter is remanded to Referee Howell for further action consistent with this order.

Board Member Gunn dissenting.

I disagree with the majority's decision to remand this matter to the Referee for further proceedings. Such proceedings will only consume more administrative time, energy and expense and delay the inevitable result in this case.

ORS 655.520(3) provides that an inmate injury claim "shall be barred" if not filed within 90 days. (Emphasis supplied). I find nothing in the statutes that requires the Department to give a reason for denying an untimely filed claim. Because it would serve no purpose to remand this case for further proceedings, I dissent.

In the Matter of the Compensation of
MICHELLE R. LYON, Claimant
WCB Case Nos. 92-15842, 92-04251 & 92-04252
ORDER ON REVIEW
Donald Hooton, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of that portion of Referee Mongrain's order which affirmed Orders on Reconsideration that awarded claimant no unscheduled permanent disability for her low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

In August 1991, claimant changed jobs and began working as a chop saw operator. (Ex. 11-2). Claimant's employer is engaged in lumber manufacturing. (Ex. 13).

The chop saw operator job is best described by DOT code 667.685-074, cut-off saw operator II (woodworking). This job requires "medium" strength and has a specific vocational preparation (SVP) value of 2.

Claimant obtained a high school diploma in 1979. (Ex. 1).

Claimant's attending physician at the time of claim closure was Dr. Webb. (See Ex. 25).

We adopt the Referee's findings of ultimate fact, except that we do not adopt finding number 4. Instead, we make the following finding.

The preponderance of relevant medical evidence establishes a level of impairment of 5 percent due to claimant's low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed two Orders on Reconsideration, issued September 14, 1992 for an October 1991 injury and December 22, 1992 for a May 1991 injury, neither of which awarded any unscheduled permanent disability for a low back condition. In doing so, the Referee found that the weight of medical evidence established only an uncertain level of impairment. (Opinion and Order at 5). Claimant contends that she is entitled to an award of unscheduled permanent disability for her low back condition. We agree.

In rating the extent of claimant's permanent disability, we apply the disability standards in effect at the time of determination. The Determination Orders issued June 19, 1992 and June 22, 1992. Therefore, we apply the standards which became effective March 13, 1992. WCD Admin. Order 6-1992. We apply former OAR 436-35-270 through 436-35-450 for rating unscheduled permanent disability.

Impairment

Only the attending physician at the time of claim closure may make impairment findings, unless a medical arbiter is appointed pursuant to ORS 656.268(7). ORS 656.245(3)(b)(B); OAR 436-35-007(9). Impairment findings made by other medical providers may be used only if the attending physician ratifies those findings. OAR 436-35-007(8); Alex J. Como, 44 Van Natta 221 (1992). Impairment findings which the attending physician has not ratified may not be considered, even for impeachment purposes. Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994).

Here, Dr. Webb, the attending physician at the time of closure, performed a closing examination on April 28, 1992. (Ex. 25). He adopted the inclinometer measurements done by Ms. Iverson in a second level physical capacities examination on April 2, 1992. (See Exs. 23, 25). Dr. Webb did not ratify any other impairment findings made by either consulting or examining physicians. No medical arbiter was appointed. Therefore, the only relevant reports for determining the extent of claimant's impairment are those authored by Dr. Webb and Ms. Iverson.

Although Dr. Webb measured claimant's lumbar range of motion, he does not indicate the method of measurement used, nor does he provide a specific measurement for lumbar flexion. Instead, Dr. Webb specifically refers to Ms. Iverson's inclinometer measurements. Because the measurements done by Ms. Iverson are consistent with the Director's rules and were ratified by the attending physician, we rely on Ms. Iverson's report for impairment findings. See OAR 436-35-007(4).

According to the physical capacities examination, claimant's lumbar flexion and extension measurements were not valid. Therefore, we do not use them. However, lateral flexion measurements were valid and were measured as follows: left lateral flexion = 13 degrees, and right lateral flexion = 12 degrees. (Ex. 23-2). 13 degrees lateral flexion equals 2.4 percent impairment, and 12 degrees lateral flexion equals 2.6 percent impairment, for a total impairment of 5 percent. Former OAR 436-35-360(21), (22).

Age

Claimant was less than 40 years old at the time of determination. (Ex. 13). Therefore, the value for age is 0. Former OAR 436-35-290.

Formal Education

Claimant had a high school diploma at the time of determination. (Ex. 1). Therefore, the value for formal education is 0. Former OAR 436-35-300(3)(a).

Education-Skills

The highest specific vocational preparation (SVP) level achieved by the worker in the ten years preceding the date of determination is used to determine the value for skills. The SVP is determined by the Dictionary of Occupational Titles (DOT) code which most accurately describes the job. Former OAR 436-35-300(4).

Based on the record in this case, we conclude that claimant's highest SVP is 2 for her job as a "chop saw operator." (See Ex. 13). This job is most accurately described as "cut-off saw operator II" in the woodworking industry, DOT code 667.685-074. Claimant performed the "chop saw operator" job for at least six months, the maximum preparation period specified for a job classified as SVP 2. (See Exs. 11-2, 13). Therefore, claimant is entitled to an SVP value of 4. Former OAR 436-35-300(4)(e).

Because we cannot determine from the record whether claimant does or does not hold "a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less," claimant is not entitled to an additional value under former OAR 436-35-300(5).

Therefore, the total education value is 4.

Adaptability

The adaptability value is determined by comparing claimant's prior strength with her residual functional capacity. Former OAR 436-35-310. Claimant's job-at-injury required "medium" strength (DOT 667.685-074, cut-off saw operator II, woodworking). Claimant's residual functional capacity is "light," based on the attending physician's release and the job to which claimant had returned to work at the time of determination. (See Exs. 25-1, 31-2, 44, 48). Therefore, claimant is entitled to an adaptability value of 3. Former OAR 436-35-310(3).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value of 0 is added to her education value of 4, the sum is 4. When that value is multiplied by claimant's adaptability value of 3, the product is 12. When that value is added to claimant's impairment value of 5, the result is 17 percent unscheduled permanent disability. Former OAR 436-35-280.

Claimant's permanent disability is for her low back condition related to the October 23, 1991 low back injury claim. (Ex. 25-1). This claim was closed by a Determination Order issued June 22, 1992, which was affirmed by an Order on Reconsideration issued September 14, 1992. (Exs. 36, 46). Therefore, because we have found that claimant is entitled to unscheduled permanent disability for her low back condition, we reverse that portion of the Referee's order which affirmed the September 14, 1992 Order on Reconsideration. Instead, we modify the September 14, 1992 Order on Reconsideration and find claimant entitled to 17 percent unscheduled permanent disability for her low back condition.

ORDER

The Referee's order dated August 25, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which affirmed the September 14, 1992 Order on Reconsideration is reversed. The September 14, 1992 Order on Reconsideration is modified to award claimant 17 percent (54.4 degrees) unscheduled permanent disability. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting.

Because I agree with the Referee's conclusion that claimant failed to establish the existence of permanent physical impairment, I respectfully dissent.

I, too, rely on the medical reports of Dr. Webb and Ms. Iverson for establishing the extent of claimant's permanent physical impairment, if any. (Exs. 23, 25). However, I find that neither report provides any consistent measurement of impairment. In conducting the physical capacities examination, Ms. Iverson noted specific inconsistencies and invalid measurements. Dr. Webb concurred in Ms. Iverson's examination, specifically noting that inconsistencies were identified. Thus, because claimant's examination findings were inconsistent, I find that claimant failed to provide any valid measurement of impairment.

Furthermore, after my review of the record, I agree with the Referee's conclusion that the record as a whole casts serious doubt on the reliability of any medical findings that are within the claimant's control, such as range of motion limitations. (See Opinion and Order at 6). Accordingly, I conclude that claimant is not entitled to any unscheduled permanent disability because the medical evidence fails to establish the existence of any valid physical impairment. Therefore, I would affirm the Referee's order.

In the Matter of the Compensation of
MARK A. NEWKIRK, Claimant
WCB Case Nos. 92-15332 & 93-01664
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Referee Hazelett's order that: (1) set aside SAIF's denial of claimant's "new injury" claim for a right shoulder condition; and (2) upheld Aetna Life & Casualty's denial of claimant's aggravation claim for the same condition. Claimant cross-requests review of the Referee's attorney fee award. On review, the issues are compensability, responsibility and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's stipulated facts and findings of fact except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee held that Aetna's acceptance of claimant's right elbow condition was not a "de facto" acceptance of the right shoulder condition. Applying the last injurious exposure rule to claimant's occupational disease, the Referee initially assigned responsibility to SAIF's insured because claimant was working for SAIF's insured on the first date of disability. The Referee found that responsibility remained with SAIF's insured because it did not prove that it was impossible for claimant to have incurred the condition as a result of his employment with SAIF's insured. We disagree with the Referee's analysis and conclusion.

Procedural Matters

As a threshold matter, Aetna argues that the Referee had no jurisdiction to address claimant's shoulder aggravation claim because claimant's request for hearing was untimely. We disagree.

On November 18, 1992, Aetna disclaimed responsibility for claimant's "aggravation and current right shoulder strain and right elbow strain." (Ex. 30). According to Aetna, claimant's Request for Hearing on the November 18, 1992 denial challenged only "responsibility, penalties and attorneys' fees" and was not sufficient for challenging the aggravation denial. Aetna argues that claimant's request for hearing challenging the aggravation denial was untimely because it was not filed until March 31, 1993.

We disagree that claimant's November 1992 Request for Hearing challenged only responsibility, penalties and attorney fees. The Request for Hearing states that it concerns the denial dated November 18, 1992, responsibility under ORS 656.307 and penalties and attorney fees for unreasonable denial. Claimant's request for hearing clearly refers to Aetna's November 18, 1992 denial. Claimant's Request for Hearing on March 31, 1993 merely clarified the issues. See OAR 438-06-031 (party who requested the hearing shall list all issues to be raised). Claimant is not precluded from arguing that Aetna is responsible for an aggravation claim.

Next, Aetna contends that it cannot be found responsible for claimant's shoulder condition because of the doctrine of claim preclusion. Inasmuch as this theory was not presented at hearing, we are not inclined to consider this argument on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Nevertheless, even if we addressed the issue, we would reject Aetna's assertion. Aetna argues that claimant should have litigated whether the shoulder was a compensable condition of the accepted claim at the November 17, 1992 hearing regarding an Order on Reconsideration arising from claimant's claim with Aetna. Instead, claimant made a premature closure argument.

Aetna did not deny the shoulder condition until after the November 17, 1992 hearing. Moreover, the factual basis for the November 1992 and September 1993 hearings were entirely different. At the November 1992 hearing, the issue was whether claimant's compensable elbow condition was medically stationary at closure on April 9, 1992. The issues at the September 1993 hearing were compensability and responsibility for claimant's right shoulder condition after his work with SAIF's insured. We conclude that claimant is not precluded from litigating his right shoulder condition.

Merits

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 involves the "same condition" as the prior accepted claim processed by Aetna. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993). Aetna accepted the claim for "right forearm strain" in March, 1992. SAIF argues that Aetna is the responsible insurer because claimant injured his right shoulder in January 1992 while working for Aetna's insured. Claimant joins in SAIF's argument.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. ORS 656.005(7); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (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. Id.

The medical evidence is divided as to whether claimant's current shoulder condition involves the "same condition" as the claim accepted by Aetna. When there is a dispute between medical experts, we give more weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We tend to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

We conclude that claimant's right shoulder condition arose directly from the January 23, 1992 industrial accident he sustained while working for Aetna's insured. The medical reports indicate that claimant had shoulder pain even before the January 23, 1992 incident with Aetna's insured. Dr. Schjelderup's early January 1992 chart notes referred to "elbow/shoulder pain" and stated that claimant had pain on the lateral epicondyle, now also with shoulder pain. (Ex. 1). On January 23, 1992, claimant was injured at work and went to the emergency room. Claimant was examined by Dr. Wilhelm, who reported that he complained of "pain that goes down his lateral forearm and sometimes up to his shoulder, but his greatest degree of pain seems to be in his lateral elbow." (Ex. 4).

Dr. Button examined claimant on February 17, 1992 and stated that claimant had "point tenderness over the longhead of the biceps tendon at the shoulder level." (Ex. 6). Dr. Button recommended physical therapy and claimant was treated for his elbow and shoulder. (Exs. 6 & 8; Tr. 30-31).

On March 20, 1992, Dr. Wilson examined claimant and stated that claimant had "developed significant symptoms of lateral epicondylitis and secondarily some shoulder problems." (Ex. 14). Dr. Wilson found that claimant was "quite tender over the AC joint and has significant irritability on forward flexion which compresses the AC joint but no true impingement of the shoulder." (Id.) An x-ray of his shoulder was normal.

Claimant was not diagnosed with a shoulder condition until August 1992, two months after he began working for SAIF's insured. On August 5, 1992, claimant was examined by medical arbiter, Dr. Becker, who noted that claimant had said his "right shoulder feels like it is separated." (Ex. 23). Dr. Becker diagnosed arthralgia in claimant's right acromioclavicular joint. (Id). On November 3, 1992, Dr. Rabie diagnosed "right shoulder and elbow strain, chronic recurrent pains, probably secondary to rotator cuff tendinitis." (Ex. 25). Dr. Rabie treated claimant for his shoulder condition for the first time in November 1992. (Id.) An MRI later showed that claimant had either tendinitis or a rotator cuff tear. (Ex. 42).

Aetna relies on the opinion of Dr. Rabie, one of claimant's treating physicians. Dr. Rabie had reviewed Dr. Becker's August 5, 1992 report and stated:

> "[Dr. Becker's report] clearly indicates to me that the second job with [SAIF's insured], as of June 10, 1992, should be held liable for any worsening or aggravation that Dr. Becker clearly states is present in his dictated report of the diagnosis when he states, 'Right elbow lateral epicondylitis dating back by history to the Fall of 1991 made worse by heavy laboring work and partially relieved by aspirin and tennis elbow band.' I would assume that 'made worse' would mean an aggravation of his condition. I would therefore concur with you that the second employer, [SAIF's insured], was to a major contributing degree the cause of his renewed symptoms in the lateral epicondyle." (Ex. 29; emphasis added).

We do not find Dr. Rabie's report persuasive because it does not discuss causation of claimant's shoulder condition. Dr. Rabie focused only on the worsening of claimant's right elbow condition. Dr. Button deferred to Dr. Rabie's opinion on causation since he was the treating physician. (Ex. 34). Because Dr. Button's opinion suffers from the same deficiencies as Dr. Rabie's opinion, we do not find it persuasive. See Somers v. SAIF, supra.

In contrast, we find the opinions of Drs. Fuller, Tilson and Radecki to be more persuasive because they are better reasoned and based on complete information. Those opinions establish that claimant injured his right shoulder while working for Aetna's insured. Dr. Fuller performed a medical evaluation on claimant for SAIF and reported:

> "Whatever the diagnosis turns out to be, it is obvious that his neck, right shoulder, elbow, and hand complaints are a continuation of his initial right arm condition resulting from use of the rivet buster and concrete drill, all of which pre-dated his 6/12/92 hire date with [SAIF's insured]. All of these symptoms are present in the medical record prior to this date. * * *
>
> "There is no new pathology developed since 6/12/92. His complaints since that date are identical to his complaints before that date. Therefore, his current neck and right arm presentation represents the condition he has had ever since working at [Aetna's insured]. This condition as yet is not fully diagnosed pending an MRI of his neck." (Ex. 44).

In Dr. Fuller's deposition, he stated that a torn rotator cuff is not something that physicians are able to find consistently. (Ex. 57-40). He stated that it is not that unusual to have a tear of the rotator cuff and still have a normal exam and be asymptomatic. (Id).

Dr. Tilson, an orthopedic consultant, reported that "the 1-23-92 incident is the major contributing factor to [claimant's] ongoing symptomatology based principally on the history. I feel that the single incident described and ascribed to that date could clearly produce a small intrasubstance tear of the rotator cuff with his ongoing symptomatology." (Ex. 52).

Dr. Radecki reported that claimant's "present complaints are most likely a continuation of the condition which did predate his employment at [Aetna's insured] on June 12, 1992. The patient confirms this." (Ex. 35). Dr. Radecki also stated that there was no evidence of any new pathology having developed since June 12, 1992. (Id.)

A condition that arises belatedly is not necessarily a "consequential condition." David B. Bennett, 46 Van Natta 529 (1994); Virgil A. Ray, 45 Van Natta 1085 (1993). The key inquiry is whether the condition or need for treatment is caused directly by the industrial accident, or whether it is caused in turn by the compensable injury. Albany General Hospital v. Gasperino, supra.

We conclude that the persuasive medical evidence establishes that claimant's right shoulder condition arose directly from the January 23, 1992 industrial accident he sustained while working for Aetna's insured. In reaching this conclusion, we rely on the persuasive opinion presented by Dr. Fuller, as supported by Dr. Tilson and Dr. Radecki. Since claimant has proved that the work injury for

Aetna's insured was a material contributing cause of his shoulder condition, he has established the compensability of his shoulder under the Aetna claim. Inasmuch as this shoulder condition is the "same condition" for which responsibility is presently disputed, ORS 656.308(1) applies to this claim.[1]

Responsibility

In order for Aetna to shift responsibility for claimant's shoulder condition to SAIF, it must establish that, during the employment with SAIF's insured, claimant experienced a new compensable injury or occupational disease. See ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993). The evidence shows that claimant's current shoulder condition did not result from a discrete incident or period of work activity after SAIF's insured went on the risk. Thus, claimant's work exposure at SAIF's insured is analyzed under an occupational disease theory. See Valtinson v. SAIF, 56 Or App 184 (1992). In order to establish a new occupational disease, Aetna, as the carrier with an accepted claim, has the burden of establishing that claimant's work activities at SAIF's insured were the major contributing cause of a worsening of claimant's right shoulder condition. See ORS 656.802(1); Liberty Northwest Ins. Corp. v. Senters, supra.

Aetna argues that the record establishes that claimant's medical treatment for his right shoulder arose after his employment with SAIF's insured. According to Aetna, claimant had a full release to return to work when he started working for SAIF's insured and after two days of heavy repetitive work he experienced intense shoulder pain. Aetna relies on claimant's testimony stating that after he began working for SAIF's insured, his shoulder pain became primary, rather than secondary. Aetna argues that claimant's shoulder condition became progressively worse after he began work with SAIF's insured.

The medical opinion which arguably supports Aetna's position is that of Dr. Rabie. However, Dr. Rabie's report, at most, indicates that claimant's work for SAIF's insured was the major cause of his increased symptoms of his elbow condition.

On the other hand, the reports of Drs. Fuller, Tilson and Radecki establish that claimant's shoulder condition was caused by his January 23, 1992 injury with Aetna's insured. The opinions of Drs. Fuller and Radecki state that no new pathology developed after June 12, 1992, when claimant began working for SAIF's insured. Those medical reports are also consistent with claimant's testimony that his shoulder troubled him throughout both jobs. Claimant testified at the November 1992 hearing that his shoulder condition was "terrible" at the time he started working for SAIF's insured and that he had been taking Motrin and aspirin all along. (Ex. 28-27 & 28-28).

We are not persuaded that claimant's work activities with SAIF's insured were the major contributing cause of a worsening of his shoulder condition. Rather, as discussed above, the persuasive medical opinions establish that claimant's shoulder condition was caused by his January 23, 1992 injury with Aetna's insured and, at most, claimant's work activities for SAIF's insured resulted in increased symptoms. Thus, because Aetna has not established that claimant sustained a new occupational disease, Aetna remains responsible for claimant's current condition.

In claimant's cross-request for review, he requests attorney fees if we find that Aetna is responsible for his shoulder condition. Inasmuch as we have found Aetna is responsible for the claim, Aetna is likewise responsible for the attorney fee award granted by the Referee. In addition, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by Aetna. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's affidavit and statement of services, as well as Aetna's objections to that statement), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review devoted to the attorney fee issue.

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[1] Aetna argues that SAIF failed to issue a disclaimer of responsibility pursuant to ORS 656.308(2). Even if SAIF failed to comply with the disclaimer notice of ORS 656.308(2), such a violation would preclude SAIF from avoiding responsibility for the claim by asserting that Aetna is liable. Noncompliance with the disclaimer statute would neither prevent Aetna from attempting to shift responsibility to SAIF or preclude claimant from proceeding to prove the compensability of his claim against SAIF. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (insurer's failure to comply with ORS 656.308(2) did not preclude the claimant from pursuing compensability on timely filed claim against other insurer).

ORDER

The Referee's order dated October 13, 1993 is reversed in part. SAIF's denial is reinstated and upheld. Aetna's denial is set aside and the claim is remanded to Aetna for processing according to law. Aetna is responsible for the Referee's attorney fee award. For services on Board review, claimant's attorney is awarded $1,500, to be paid by Aetna. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JEANETTA RAY, Claimant
WCB Case No. 93-05635
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee McCullough's order that upheld the self-insured employer's denial of her injury claim for a neck condition. In its respondent's brief, the employer contests those portions of the Referee's order that: (1) awarded interim compensation; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are compensability, interim compensation and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt those portions of the Referee's "Opinion and Conclusions" which determined that claimant's injury claim was not compensable.

Temporary Disability

Finding that the employer received notice of claimant's injury claim on March 2, 1993, the Referee concluded that claimant was entitled to interim compensation from March 2 to March 30, 1993 (the date claimant was released to regular work). The Referee also assessed a 25 percent penalty based on this unpaid interim compensation. See ORS 656.262(6).

The employer challenges the Referee's decision. It asserts three arguments: (1) failure to pay interim compensation is not a delay or refusal to pay compensation under ORS 656.262(10)(a); (2) its failure to pay was justifiable because to do otherwise would have waived its defense of untimely filing; and (3) any interim compensation should be offset by any concurrent unemployment compensation she may have received.

To begin, the employer asserts that failure to pay interim compensation is not a refusal to pay "compensation" under ORS 656.262(10)(a). The employer cites no authority for such a proposition and we have found none. To the contrary, since interim compensation is composed of temporary disability, it constitutes a "benefit" within the statutory definition of "compensation." See ORS 656.005(8); 656.262(4). Consequently, we reject the employer's first argument.

Secondly, the employer argues that withholding payment of claimant's interim compensation was not unreasonable because to do otherwise would have been construed as a waiver of the defense of untimely filing. We disagree for the following reason.

A claimant is required to give timely notice of an injury within 30 days. ORS 656.265(1). Failure to give timely notice of an injury is an affirmative defense that may bar the claim for compensation. See generally, Inkley v. Forest Fiber Products Co., 288 Or 337 (1980); Argonaut Ins. Co. v. Mock, 95 Or App 1, rev den 308 Or 79 (1989).

The first installment of compensation shall be paid no later than the 14th day after receiving notice of the injury claim. ORS 656.262(4)(a). If the carrier begins making interim payments under ORS 656.265(4)(b), then it waives the right to assert timeliness of notice as a defense. Wilson v. Roseburg Forest Products, 113 Or App 670, 672 (1992); Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 461 (1984).

Conversely, ORS 656.265(4)(b) does not apply if the carrier has not begun payment of temporary disability. Wilson v. Roseburg Forest Products, supra, 113 Or App at 673. The carrier retains the timeliness of notice defense so long as the defense is raised at the first hearing on the claim for compensation. ORS 656.265(5). Therefore, if temporary disability payments are not paid within 14 days of the injury claim, then the carrier may still assert its timeliness of notice as a defense at hearing. James E. Marek, 42 Van Natta 2578, 2579 (1990) (In order to avoid a penalty for failure to timely commence payment of compensation, while also avoiding a waiver of the timeliness defense, the carrier must raise the timeliness defense by denial within the 14 days provided by ORS 656.262(4)(a)).

Failure of the carrier to pay interim compensation within 14 days of its receipt of notice of the injury claim may be dispositive with regard to the reasonableness of that claims processing decision. Van Horn v. Jerry Jerzel, Inc., supra. In other words, penalties and attorney fees may be assessed where the failure to pay interim compensation is found to be unreasonable. James E. Marek, supra.

Here, claimant alleges that her compensable injury occurred on January 10, 1993. On February 16, 1993, claimant's treating physician, Dr. Johnson, sent the employer's adjusting agent a Form 827 (workers' compensation medical claim form) wherein claimant was taken off work and "time loss" was authorized. (Ex. 3). The employer received notice of this claim on March 2, 1993. On May 3, 1993, the employer's adjusting agent denied compensability of the injury claim, contending that the injury did not arise in the course and scope of employment, nor was the injury claim timely filed. (Ex. 8).

Claimant never received any interim compensation from the time the employer received notice of the claim (March 2) to the date claimant was released to regular work (March 30). In accordance with ORS 656.262(4)(a), the employer was obligated to either begin payment of interim compensation within 14 days of March 2, 1993, or to deny the claim based upon untimely filing. The Referee concluded that the record did not reflect any excuse for the employer's failure to pay claimant temporary disability from March 2, 1993 to March 30, 1993. Consequently, claimant was awarded interim compensation, in addition to an assessed penalty under ORS 656.262(10). We agree with the Referee's decision.

As discussed above, a carrier may choose to preserve its defense that it did not receive timely notice of an injury claim. The preservation of this defense requires that the employer either: (1) issue a denial of compensability within the 14 day period; or (2) withhold payment of interim compensation. Van Horn v. Jerry Jerzel, Inc., supra. If the reason for not providing interim compensation was claimant's untimely notice of injury, then the employer was obligated to deny the claim within the requisite 14 day period; preservation of the untimely filing defense is not a reasonable ground to withhold interim compensation where the defense is known and assertable prior to the expiration of the statutory 14 day period. See generally, Demetrios C. Meletis, 45 Van Natta 1047 (1993) (Where claimant left work due to his compensable condition and all the evidence available to the insurer indicated that claimant left work because of a medical condition, the insurer's failure to pay interim compensation was held to be unreasonable).

Refusal to pay interim compensation is a claims processing decision that necessarily assumes the risk of assessed penalties and attorney fees if that decision is later found to have been unreasonable. Van Horn v. Jerry Jerzel, Inc., supra; James E. Marek, supra. Here, the employer did not raise the untimely notice defense within 14 days after its receipt of claimant's injury claim. Rather, the employer simply refused to pay claimant interim compensation. The employer provided no reasonable explanation for this untimely claims processing action. Therefore, we reject the employer's argument that its failure to pay interim compensation was justified.

Lastly, the employer argues that claimant's award of interim compensation should be offset by unemployment benefits the employer contends that she received between March 2 and March 30. There would appear to be authority permitting a carrier to offset a claimant's temporary disability benefits for any period coinciding with the receipt of unemployment benefits. See Wells v. Pete Walker's Auto Body, 86 Or App 739, 742 (1987); Shirley J. Sanderson, 44 Van Natta 484, 484 (1992).

Nevertheless, we need not resolve this question in this proceeding. The Referee has found that claimant is entitled to interim compensation benefits. We have affirmed that finding. Now it is up to the employer to determine the amount of claimant's interim compensation award. Inasmuch as the calculation of interim compensation is a claim processing matter, the employer has the initial responsibility to determine what, if any, offset of unemployment benefits is appropriate. After doing so, if claimant objects to the employer's calculation of those interim benefits, then claimant can request another hearing. See ORS 656.283(1). At that time, the parties will be able to fully develop a record should such a "claim processing/calculation" issue arise.

Penalties and Attorney Fees

We adopt that portion of the Referee's order that awarded claimant penalties pursuant to ORS 656.262(10).

Claimant is entitled to an assessed attorney fee for services on review concerning the employer's objections to the Referee's interim compensation 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 attorney fee for claimant's counsel's services on review concerning the interim compensation issue is $300, 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 reply brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for her counsel's unsuccessful services devoted to the compensability issue. Likewise, claimant is not entitled to an attorney fee for any efforts pertaining to the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated September 14, 1993 is affirmed. For services on review concerning the interim compensation issue, claimant's attorney is awarded an assessed attorney fee of $300, payable by the self-insured employer.

In the Matter of the Compensation of
MARK A. ROSENBLOOM, Claimant
WCB Case No. 92-08790
ORDER ON RECONSIDERATION
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our May 26, 1994 Order on Review that upheld the insurer's denial of claimant's aggravation claim for an adjustment disorder. Specifically, claimant contends that the Board should have relied on the opinions of Drs. Farley, Larsen, and Takacs, over that of examining psychiatrist Parvaresh, to find a worsening (aggravation) of claimant's adjustment disorder.

We write to clarify our prior order. In our May 26, 1994 order, although we found that claimant's original accepted consequential psychological condition (adjustment disorder) had not worsened, we found (affirming the Referee) that claimant's current disabling psychological condition (obsessive/compulsive disorder) and need for treatment is compensable as a consequence of the 1985 injury. Therefore, we concluded that claimant sustained an additional compensable consequential psychological condition (obsessive/compulsive disorder) in April 1992, rather than an aggravation of his original consequential psychological condition (adjustment disorder).

Turning to claimant's request for reconsideration, we find that the opinions of Dr. Farley, current treating psychiatrist, Dr. Larsen, former treating psychiatrist, and Dr. Takacs, attending osteopathic physician, provide little support for claimant's aggravation claim.

Claimant has three diagnosed psychological conditions: a noncompensable preexisting anxiety disorder, the consequential obsessive/compulsive disorder with symptoms of rumination and preoccupation with physical health which we found compensable in our May 26, 1994 Order on Review, and the consequential adjustment disorder. After our review of the record, we continue to find that only Dr. Parvaresh expressed an opinion regarding the worsening of claimant's adjustment disorder. Dr. Parvaresh distinguished between claimant's anxiety disorder, obsessive/compulsive disorder, and adjustment disorder. Then, in a well-reasoned report, he persuasively explained that claimant's adjustment disorder has not worsened since 1990.

On the other hand, Drs. Farley, Larsen, and Takacs opined that claimant currently requires psychological counseling for his anxiety disorder and obsessive/compulsive disorder. Noting that claimant was having almost continuous panic attacks, Dr. Takacs indicated that claimant's anxiety disorder worsened in April 1992. Dr. Larsen commented that claimant had become more preoccupied with his physical health as he perceived his physical condition to worsen. Finally, Dr. Farley stated that claimant experienced a worsening of his anxiety symptoms.

Therefore, claimant has established a second compensable consequential condition (obsessive/compulsive disorder) which, based upon the medical evidence in this record, is currently disabling. The carrier shall process this claim pursuant to law. Claimant has not established a worsening of the first consequential condition (adjustment disorder).

Accordingly, we withdraw our May 26, 1994 order. On reconsideration, as supplemented and clarified herein, we adhere to and republish our May 26, 1994 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
JAMES V. JOHNSTON, Claimant
WCB Case No. 92-16193
ORDER OF ABATEMENT
Susan D. Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Wood, Tatum, et al., Defense Attorneys

On June 20, 1994, we vacated a Referee's order which had dismissed claimant's hearing request seeking penalties under ORS 656.262(10) or attorney fees under ORS 656.386(1) regarding a medical service dispute which had resulted in a Director's order under ORS 656.327(2) finding a disputed medical service to be appropriate. Reasoning that claimant's request for a carrier-paid attorney fee award under ORS 656.386(1) constituted a "question concering a claim," we concluded that such a question combined with claimant's request for penalties vested the Hearings Division with jurisdiction to address the issues.

On our own motion, we withdraw our June 20, 1994 order. We take this action to further consider the question of whether claimant's request for an attorney fee award under ORS 656.386(1) constitutes a matter concerning a claim when the services on which the requested award were based arose from a medical service dispute that was resolved pursuant to a Director's order under ORS 656.327(2).[1] See ORS 656.704(3).

To assist us in reconsidering this question, the parties are granted an opportunity to submit supplemental briefs. To be considered, these supplemental briefs must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

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[1] Concerning claimant's entitlement to an attorney fee award under ORS 656.386(1) for services rendered in obtaining the Director's order under ORS 656.327(2) finding the recumbent cycle to be appropriate medical treatment, the parties may wish to address on remand to the assigned Referee the effect, if any, the Board's holding in Sherry Y. Drobney, 46 Van Natta 964 (1994), has on this issue.

In the Matter of the Compensation of
JAMES W. NICHOLLS, Claimant
WCB Case No. 91-01349
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

Pursuant to our May 24, 1994 Order on Remand, we affirmed a Referee's order which upheld the insurer's denials of claimant's chiropractic treatments. Claimant has moved for reconsideration of our decision.

In order to consider claimant's motion, we withdraw our May 24, 1994 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JULIE A. HENRY, Claimant
WCB Case No. 92-15136
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Spangler's order that reduced claimant's unscheduled permanent disability for a low back condition from 29 percent (92.8 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant's job at injury was Stock Clerk (DOT # 299.367-014), which is classified as heavy work. At the time of reconsideration, claimant had returned to a part-time, modified stock clerk job. She was limited to lifting no more than 20 pounds and had restrictions on squatting, bending and twisting. (Tr. 40, 43, 44). Claimant's residual functional capacity (RFC) at the time of reconsideration was light/sedentary.

We do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Disability Rating - Applicable Standards

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994). Claimant's claim was closed by an August 24, 1992 Determination Order. Consequently, the standards effective March 13, 1992, as set forth in WCD Admin. Order 6-1992, apply.

Disability Rating

The Referee, giving greater weight to the attending physician's opinion, concluded that claimant had no impairment associated with her December 1991 low back injury. Alternatively, the Referee concluded that claimant's unscheduled permanent disability award should be reduced to 13 percent, based on an adaptability value of 2, rather than the value of 6 as found by the Department. Claimant contends that the unscheduled permanent disability award should be increased. She specifically raises the issues of impairment and adaptability.

Impairment

Dr. Isaacson, claimant's attending physician, diagnosed claimant's condition as left sacroiliac joint dysfunction, based on claimant's complaints that, when she squatted, she experienced low back pain and could not get back up. (Ex. 16). A medical arbiter, Dr. Gritzka, was appointed. He explained that claimant's sacroiliac joint dysfunction was her primary condition and that her lumbosacral dysfunction was secondary. He concluded that claimant was unable to repetitively use her lumbosacral spine and left sacroiliac joint due to a chronic and permanent medical condition. He qualified this statement by saying that claimant's condition did not render her totally unable to repetitively use her low back, but that she was permanently precluded from frequently stooping, crouching, crawling,

kneeling, twisting, climbing and balancing. This qualification, in and of itself, does not defeat claimant's impairment rating. See Glenda R. Linderman, 46 Van Natta 47, 48 (1994) (Medical evidence of at least a partial loss of ability to repetitively use a body area establishes an unscheduled chronic condition impairment).[1]

Initially, when Dr. Isaacson declared claimant to be medically stationary, she declined to release claimant to return to work at the employer because of her limitations on standing, bending and lifting. (Ex. 37). Dr. Isaacson did not perform the closing examination herself. Instead, she concurred with the opinion of Dr. Kayser, who concluded that claimant could return to work without limitation. Dr. Kayser examined claimant's low back for lumbar pathology and loss of range of motion, but did not focus on her sacroiliac joint dysfunction.

We are less persuaded by Dr. Isaacson's concurrence for two reasons. First, Dr. Kayser did not evaluate claimant's sacroiliac joint dysfunction. Second, Dr. Isaacson did not reexamine claimant or explain her change of opinion regarding claimant's ability to return to work. Therefore, based on the findings of the medical arbiter, we conclude that claimant has a permanent, chronic low back condition, which entitles her to a 5 percent impairment value. See former OAR 436-35-320(5).

Adaptability

Claimant does not contend that the DOT job description assigned by the Order on Reconsideration and the Referee is inaccurate. Rather, she contends that the Referee erred in his evaluation of the strength demands of her job at injury. We agree.

Claimant's adaptability value is based on the strength demands of the worker's job at the time of injury compared with the worker's maximum RFC at the time of determination. Former OAR 436-35-310(1) and (2). Former OAR 436-35-280(3)(g) provides that prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury.

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. Nevertheless, the fact remains that the most applicable DOT determines the strength category. See former OAR 436-35-270(3)(g); William D. Knox, 45 Van Natta 854 (1993). Claimant's testimony is relevant to the determination of which DOT most accurately describes her at-injury job. Kathryn D. Parsons, 45 Van Natta 954 (1993). However, claimant's testimony may not be relied upon to determine that no DOT description accurately describes the job and that, therefore, the strength category must be determined without regard to the DOT. Id.

The Referee concluded that claimant's strength demand was medium, based on her testimony at hearing. However, as stated above, the strength requirement for claimant's job must be determined by the DOT job description. The employer did not submit, and we have not found, a DOT job description that is more appropriate for claimant's work as a stock clerk. Furthermore, the employer testified that claimant was performing stock clerk work without modification. (Tr. 46, 47). We thus conclude that the DOT description that most accurately describes claimant's job at the time of injury establishes her strength category as heavy.

At the time of reconsideration, claimant was limited to lifting no more than 20 pounds and was restricted from squatting, bending and twisting (Exs. 53-6, Tr. 43, 44), which establishes her RFC as light/sedentary work. Former OAR 436-35-270(d) and (e). Thus, the comparison of strength demands at the time of injury and the RFC establishes an adaptability value of 6. Former OAR 436-35-310(3).

We proceed to assemble the factors comprising unscheduled disability. Neither party contests the values assigned to age (0) or education (4). The values for age and education are added for a value of 4. Former OAR 436-35-280(4). The value for adaptability (6) is multiplied by the education value (4) for a value of 24. Former OAR 436-35-280(6). This value (24) is added to the impairment value (5) for a total of 29 percent unscheduled permanent disability to be awarded. Former OAR 436-35-280(7).

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[1] We note that Dr. Gritzka stated that claimant's condition might respond to further treatment. (Ex. 53-7). This merely hopeful statement is insufficient to establish that Dr. Gritzka expected material improvement in claimant's condition. See ORS 656.005(17). Furthermore, neither party raised the issue of premature closure.

ORDER

The Referee's order dated September 7, 1993 is reversed. The Order on Reconsideration, which awarded claimant 29 percent (92.8 degrees) unscheduled permanent disability, is reinstated and affirmed. Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed a total of $3,800.

In the Matter of the Compensation of
ZIGURDS LAURINS, Claimant
WCB Case Nos. 93-01762, 93-01810 & 93-01850
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Kemper Insurance Company (Kemper) requests review of those portions of Referee McWilliams' order that: (1) set aside its denial of claimant's aggravation claim for a left arm and neck injury; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (3) increased claimant's unscheduled permanent disability award for a neck injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 13 percent (41.6 degrees). In its brief, Kemper contends that claimant's hearing request on the Order on Reconsideration was untimely. On this basis, Kemper asserts that the Referee lacked jurisdiction to modify the Order on Reconsideration. On review, the issues are compensability, responsibility, jurisdiction and extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

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

Jurisdiction/Extent of Unscheduled Permanent Disability

Kemper objects to the Referee's order which increased claimant's unscheduled permanent disability award for a neck injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 13 percent (41.6 degrees). Specifically, Kemper argues that since it withdrew its hearing request on the Order on Reconsideration, the Referee was without authority to address the extent of claimant's unscheduled permanent disability. Based upon the following reasoning, we agree.

An October 8, 1992 Notice of Closure awarded 12 percent (38.4 degrees) unscheduled permanent disability and 7 percent (13.44 degrees) scheduled disability. (Ex. 34-1). Claimant sought reconsideration of the Notice of Closure, and on January 12, 1993, an Order on Reconsideration issued which increased claimant's scheduled award to 13 percent (24.96 degrees) for loss of use or function of the left arm. (Ex. 45-2).

On February 11, 1993, Kemper requested a hearing challenging the January 12, 1993 Order on Reconsideration's award of scheduled permanent disability. On February 12, 1993, claimant requested a hearing raising as issues compensability, responsibility and penalties and attorney fees. The hearing requests by Kemper and claimant were consolidated. On the date of the consolidated hearing (May 6, 1993), Kemper withdrew its hearing request on the Order on Reconsideration. That same day, claimant filed a supplemental hearing request seeking an increase in the unscheduled disability awarded by the Order on Reconsideration. At the hearing, Kemper objected to claimant's supplemental hearing request,

on timeliness grounds. It argued that claimant's supplemental hearing request challenging the Order on Reconsideration was untimely since it was filed more than 180 days after the date of the Notice of Closure. On this basis, Kemper contended that the Referee was without authority to modify claimant's permanent disability award.

On review, Kemper raises the same objection. Specifically, it argues that since its February 11, 1993 request for hearing was withdrawn prior to hearing, and since claimant's February 12, 1993 hearing request did not appeal the Order on Reconsideration, there was no timely request for hearing on the Order on Reconsideration. On this basis, Kemper argues that the Referee was without authority to modify the Order on Reconsideration. We agree.

Prior cases have held that, where a party's request for hearing places a permanent disability award at issue, that award is properly before the referee, even if the opposing party does not cross-request a hearing on that award. In other words, a party's appeal of the award places it in issue, and the referee may affirm, increase or decrease the award, even though the other party has not formally cross-appealed the award. See Pacific Trucking Co. v. Yeager, 64 Or App 28 (1983); Kristy R. Schultz, 46 Van Natta 294, 295 (1994); Judith L. Duncan, 45 Van Natta 1457, 1458 (1993).

However, here, only Kemper timely appealed the Order on Reconsideration. In his February 12, 1993, request for hearing, claimant raised only the issues of responsibility, compensability, penalties and attorney fees. Claimant's February 12, 1993 request for hearing did not appeal the January 12, 1993 Order on Reconsideration, nor did it raise any issues pertaining to the Order on Reconsideration.

More importantly, on the date of hearing, Kemper withdrew its hearing request challenging the Order on Reconsideration. Claimant then filed a supplemental hearing request. However, by the time claimant filed his supplemental hearing request, the time to appeal the Order on Reconsideration had run. Thus, at the time of hearing, there was no timely request for hearing on the Order on Reconsideration. Under such circumstances, we conclude that claimant's hearing request on the Order on Reconsideration, which was filed on May 6, 1993, was untimely.

This holding is consistent with prior case precedent which holds that although a formal cross-request from a Determination Order was unnecessary, the party which did not file a formal cross-request took the risk that the appealing party would withdraw its hearing request, thereby depriving the referee of authority to modify the Determination Order. See Thomas E. Harlow, 38 Van Natta 1406, 1408 (1986); Charles W. Roller, 38 Van Natta 50, 52 on recon 38 Van Natta 158 (1986), aff'd Weyerhaeuser Co. v. Roller, 85 Or App 500 (1987). Accordingly, on this record, we conclude that, since there was no timely request for hearing on the Order on Reconsideration, the Referee lacked authority to modify the permanent disability award.

In reaching our decision, we distinguish the present case from James S. Franklin, 43 Van Natta 2323 (1991). In Franklin, the insurer requested a reduction of the unscheduled permanent disability award at hearing, but did not file a formal cross-request for hearing. The claimant attempted to withdraw his hearing request on the issue of extent of unscheduled permanent disability, contending that the referee was thereby deprived of authority to review that issue. The referee disagreed and reversed the Determination Order award of unscheduled permanent disability. On Board review, we held that the claimant's withdrawal of a single issue, while still asserting other issues relating to the Determination Order, did not deprive the referee of authority to consider the insurer's challenge to the Determination Order. See also Judith L. Duncan, supra, 45 Van Natta at 1459.

By contrast, in the present case, Kemper did not attempt to raise other issues relating to the Order on Reconsideration, but rather withdrew its entire hearing request. Moreover, although claimant had also filed a request for hearing, he did not appeal the Order on Reconsideration or raise any issues relating to the Order on Reconsideration in his hearing request.

Claimant is entitled to an assessed attorney fee for prevailing over a portion of Kemper's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the denial issues is $800, to be paid by Kemper. 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 June 7, 1993, as amended on August 3, 1993, is reversed in part and affirmed in part. Claimant's supplemental hearing request concerning the Order on Reconsideration is dismissed as untimely filed. That portion of the Referee's order that modified the January 12, 1993 Order on Reconsideration and awarded an "out-of-compensation" attorney fee from the increased permanent disability is reversed. The Order on Reconsideration award of 12 percent (38.4 degrees) unscheduled permanent disability is reinstated. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $800, payable by Kemper.

Board Member Gunn dissenting.

I disagree with the majority and would hold that the Referee had jurisdiction to modify the Order on Reconsideration.

Here, claimant's and Kemper's hearing requests were consolidated for hearing. Thus, claimant knew that the extent of disability issue would be raised at hearing. In addition, Kemper did not withdraw its appeal until the date of the consolidated hearing. Under these circumstances, I believe there was jurisdiction over the Order on Reconsideration notwithstanding claimant's failure to formally cross-appeal that order.

I would hold that the issue of extent was properly before the Referee. In this regard, OAR 436-06-031 provides that if, at hearing, the evidence supports an issue not previously raised, the referee may allow the issue to be raised. If the adverse party is surprised and prejudiced as a result, the referee may continue the hearing upon a motion of the adverse party. Thus, Kemper's remedy, if it was surprised, was to request a continuance at hearing. Here, Kemper did not request a continuance or assert surprise. On this basis, I would hold that the Referee properly allowed the issue of extent of permanent disability to be raised.

In the Matter of the Compensation of
MICHAEL J. SALDI, Claimant
WCB Case Nos. 93-00181 & 92-14128
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Brown's order which upheld the self-insured employer's denials of claimant's current neck condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also adopt the Referee's first finding of ultimate fact. We do not adopt the Referee's second finding of ultimate fact; i.e., that claimant was not a credible witness.

CONCLUSIONS OF LAW AND OPINION

The Referee found, based on inconsistencies in the record, that claimant was not a credible witness. Based on that finding, the Referee concluded that claimant failed to prove legal causation; i.e., that a work injury existed that could have caused the claimed medical condition. See Harris v. Farmers' Co-op Creamery, 53 Or App 618, 621, rev den 291 Or 893 (1981). On that basis, the Referee concluded that claimant failed to prove the compensability of his current neck condition, a C7-T1 herniated disc which requires surgery.

We agree that claimant failed to prove the compensability of his current condition, but we disagree with the Referee's credibility finding. Therefore, we affirm the Referee's order based on the following reasoning.

The Referee found claimant was not a credible witness based on inconsistencies in the record. When the referee's credibility finding is based on the substantive record, rather than on a witness' demeanor, we need not defer to the referee's credibility finding. Under such circumstances, we are equally competent to evaluate the substance of claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After conducting our review, we do not find inconsistencies in claimant's description of the August 3, 1992 work incident, or of the onset and progressive worsening of his symptoms. (See Exs. 14-3, 35, 43-2, 44, 46; Tr. 6-7, 10-11). We find that claimant's testimony is essentially consistent with his description to medical providers of the onset of increased symptoms in August 1992, as well as with his note to his employer dated August 10, 1992. Accordingly, based on our review of the record, we conclude that claimant is a credible witness.

Based on our review of the record, we find that claimant experienced a "jolt" of pain in his right arm on August 3, 1992, associated with lifting a bumper at work. The pain and numbness in his arm increased gradually over the next several days until it became extreme by Saturday, August 8, 1992, causing claimant to seek medical treatment with Dr. Purtzer on August 10, 1992. Accordingly, we conclude that claimant established legal causation; that is, claimant proved the existence of a work incident on August 3, 1992 which could have caused his disability and need for medical treatment.

Claimant must also establish medical causation. Claimant has longstanding multi-level degenerative disc disease of the cervical spine, which combined with his August 1992 work injury. (See Exs. 37, 38, 43-5, 44-1, 45-6 to -7). Therefore, to establish compensability of his current cervical condition, claimant must prove that the August 1992 work injury was the major contributing cause of his resultant disability and 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, rev den 318 Or 27 (1993).

Given the presence of preexisting degenerative disc disease and the nature of claimant's injury, we find that the medical causation question is medically complex, 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).

When medical opinion is divided, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally give greater weight to the treating doctor's opinion. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to the treating doctor's opinion.

Dr. Purtzer, claimant's treating neurosurgeon, opined that the August 3, 1992 work incident is the major contributing cause of the C7-T1 herniated disc, which is the major cause of claimant's current disability and need for medical treatment. The sole explanation for his opinion is that it is based on "the temporal relationship of work to [claimant's] new radicular symptoms." (Ex. 44-2). Dr. Purtzer's August 1992 chart notes provide no further insight into the causal relationship between claimant's work activities and his current condition. (See Ex. 14-3 to -4). Finally, although Dr. Purtzer acknowledges the presence of preexisting degenerative disease, he provides no explanation of the potential interrelationship, or lack thereof, between the 1992 work injury and claimant's preexisting disease. (See Ex. 44). Under these circumstances, we find Dr. Purtzer's opinion is conclusory and not well-reasoned. Accordingly, we decline to give it greater weight. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Barbara J. James, 44 Van Natta 888 (1992), aff'd mem James v. O'Rourke, 117 Or App 594 (1993).

By contrast, we find the opinion of Dr. Woolpert, an orthopedist who examined claimant at the employer's request, to be more persuasive. Dr. Woolpert opined that, given the presence of severe, longstanding, multi-level degenerative joint disease, and the absence of an unusual traumatic episode at work when claimant experienced the onset of neck and arm pain, the major contributing cause of claimant's current need for surgery is the degenerative disease, not his August 1992 work activities. (Ex. 43-5). Dr. Woolpert viewed claimant's current condition as "a symptomatic exacerbation of a pre-existing condition." (Id).

Dr. Woolpert reiterated and expanded on this opinion in his deposition testimony. (See Ex. 45 at 4-7, 13-15). We find that the history Dr. Woolpert relied on for his opinion is consistent with

claimant's testimony regarding his work activities and the onset and development of his symptoms. In addition, because Dr. Woolpert considered the role of claimant's preexisting degenerative joint disease, we find his opinion to be better reasoned.

Relying on Dr. Woolpert's opinion, we conclude that claimant failed to establish that the August 1992 work activity was the major contributing cause of his current neck condition and need for surgery. Accordingly, we affirm the Referee's order upholding the employer's October 15 and December 7, 1992 denials.

ORDER

The Referee's order dated October 22, 1993 is affirmed.

In the Matter of the Compensation of
JIM VALLEJO, Claimant
WCB Case No. 92-07939
ORDER ON REVIEW
Max Rae, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Westerband, Neidig, and Hall.

Claimant requests review of that portion of Referee Nichols' order that affirmed an Order on Reconsideration which awarded claimant 32 percent (102.4 degrees) unscheduled permanent disability. In his brief, claimant contends that, in rating his permanent impairment, the Referee impermissibly considered medical evidence developed after the medical arbiter's report. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the "Findings" on page 3 which pertain to Dr. Binder, his evaluation, and report.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, claimant argues that none of the medical or psychological reports in the record following Exhibit 41 (the medical arbiter's report) should have been considered by the Referee, because the exhibits were all generated after the arbiter's report. Claimant contends that, although the Referee was entitled to consider the reports for purposes of aggravation, she was precluded by ORS 656.268(7) from admitting and considering the reports for purposes of determining extent of permanent disability.

The employer responds that, because claimant did not object to the admission of the aforementioned exhibits at hearing, it is too late to object to the consideration of such evidence on review.

We do not agree with the employer that claimant's failure to object to the post arbiter report exhibits is dispositive on the issue of admissibility. As noted by claimant, the exhibits in question were submitted and properly admitted for purposes of the aggravation issue. Furthermore, on the issue of impairment, it is the statute which prohibits the consideration of certain evidence. ORS 656.268(7). Accordingly, we proceed to determine whether the exhibits were properly considered for impairment purposes.

Where a medical arbiter or panel of arbiters has been appointed by the Director, ORS 656.268(7) operates to prohibit any subsequent medical evidence concerning a worker's impairment from being admitted into the record at hearing. ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself. Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). See also Gary C. Fischer, 46 Van Natta 60 (1994).

In the present case, a medical arbiter panel was appointed and issued its report dated May 18, 1992. Consequently, ORS 656.268(7) prohibits the admissibility of evidence developed after the arbiter's report. Therefore, to the extent that any of the exhibits/medical reports following the arbiter's report (Exhibit 41) relate to claimant's impairment, they may not be considered for purposes of determining impairment. Therefore, we do not consider such evidence on review. ORS 656.283(7).

Extent of unscheduled permanent disability

The Referee concluded that claimant had not established an entitlement to an impairment value for loss of range of motion in the lumbar area. We agree; however, we base our conclusion on the following reasoning.

Here, claimant relies upon the opinion of his treating doctor, Dr. Poulson, M.D., to support an award of permanent disability for his low back condition. However, in his closing examination, Dr. Poulson reported that, although claimant had lumbar pain, it was his opinion that..."we are dealing with a good deal of overlay here." Ex. 32-1. In other words, the doctor warns the finder of facts that, to a significant degree, the results of his examination cannot be relied upon for the purpose of determining the extent of claimant's impairment.

Accordingly, because claimant's treating doctor has documented claimant's function overlay in his report regarding lumbar range of motion findings (and there is no further comment or explanation from Dr. Poulson), we conclude that claimant has failed to establish that he has suffered any permanent low back impairment due to the compensable injury. See, e.g., Willa D. Tucker, 42 Van Natta 1281 (1990). The Referee's order is, therefore, affirmed.

ORDER

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

Board Member Hall specially concurring.

The majority concludes that post-arbiter report evidence should not have been considered in evaluating permanent disability. I offer this concurrence to also point out that the employer/carrier's attempt to use opinions from Laurence Binder, Ph.D., to impeach physical impairment measurements, is prohibited by ORS 656.245(3)(b)(B) and Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994).

In the Matter of the Compensation of
SHANDRA WICKMAN, Claimant
WCB Case No. 93-06106
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Black'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.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Heck, psychiatrist, the Referee found that claimant did not have a diagnosed mental or emotional disorder and found that claimant's off-the-job stressors were also a cause of claimant's condition. The Referee concluded that claimant failed to prove, by clear and convincing evidence, that her work was the major contributing cause. We agree, but offer the following analysis.

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. The mental disorder must be one that is recognized in the medical or psychological community. The employment conditions producing the mental disorder must exist in a real and objective sense. In addition, 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. Finally, there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(2) & (3). 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

Claimant relies on psychologist Moseley's opinion to establish that she does have a diagnosed mental disorder. Based on claimant's history and symptoms, Ms. Moseley diagnosed post-traumatic stress syndrome (PTSD). (Ex. 9). Claimant contends that the Referee disproved Moseley's diagnoses based on his own opinion that claimant's experience did not qualify as the sort of trauma which could produce post-traumatic stress disorder. We agree, and therefore, do not adopt the Referee's determination that claimant's work exposure was not the kind of "extraordinary psychotraumatic, precipitating event or events" required to diagnose PTSD.

We, nevertheless, find, based on the opinion of Dr. Heck, that claimant does not have a diagnosable mental or emotional disorder. Dr. Heck, psychiatrist, examined claimant and performed psychological tests. Although psychological testing indicated the possibility of an adjustment disorder with mixed emotional features or a histrionic personality disorder, Dr. Heck concluded that claimant did not meet DSM-III-R criteria for any mental disorder.

Although we generally defer to the opinion of the treating physician, there are persuasive reasons not to do so here. Weiland v. SAIF, 64 Or App 816 (1983). Ms. Moseley first saw claimant on August 4, 1993, four months after claimant first sought treatment for her emotional problems. She only saw claimant twice before rendering her opinion. Thus, she is in no better position than Dr. Heck to render an opinion regarding claimant's diagnosis. Moreover, unlike Dr. Heck, Ms. Moseley performed no psychological tests in which to support her diagnosis. Accordingly, we give Dr. Heck's opinion greater weight because it is based on the most complete information and is well-reasoned. Somers v. SAIF, 77 Or App 259 (1986).

Causation

The Referee, relying on the opinion of Dr. Heck, found that claimant failed to prove that her employment conditions, compared to nonwork stressors, were the major contributing cause of her emotional problems. We agree.

Claimant contends that she left work (on April 5, 1993) because she could no longer handle "Jim" and she was afraid of what he might do, and because her employer would not listen to her or help her. Jim was a developmentally delayed resident in the group home where claimant worked as a care provider. Jim had a tendency to be grabby, pursuing, and aggressive. Claimant had difficulty keeping Jim from hugging her, and on occasion, he would chase her. Jim also had behavioral problems with other residents in the care home.

SAIF admits that Jim had behavioral problems, yet claimant did not write up any incident reports involving herself and Jim. (Tr. 86). Weekly staff meetings were held, which beginning in February 1993 concerned primarily Jim. The recommended "ignore and redirect" behavior plan to deal with Jim's behavior, which claimant had objected to, was ultimately rejected in February or March of 1993. Thus, it appears that the employer was trying to deal with Jim's behavioral problems.

The record establishes that claimant's work and off-work stressors occurred within the same time frame. Claimant's boyfriend, whom claimant had lived with for five years and whom she had hoped to marry in June 1993, moved out in March 1993. Claimant found out that the boyfriend had been unfaithful and had also given her a venereal disease. Claimant's boyfriend had been unemployed for several months, causing financial problems and conflicts. Claimant owed rent, had been evicted, and was sued for the back rent. Her car was being repossessed. Claimant had also wanted, but did not receive any emotional support from her boyfriend regarding her work situation.

Dr. Heck concluded that the combination of these off-the-job stressors was the major contributing cause of claimant's current emotional symptoms. (Ex. 6-15). Ms. Moseley, however, related claimant's PTSD to her work environment. We discount Moseley's opinion because it does not address claimant's nonwork stressors. Susan G. Twigger, 42 Van Natta 94, 96 (1990); Betty A. Wilcox, 39 Van Natta 828, 831 (1987).

In summary, we find that claimant failed to prove that she has a diagnosed mental disorder, and that her employment conditions, compared to nonwork stressors, were the major contributing cause of her emotional problems. Also, considering the nonwork stressors, claimant failed to prove, by clear and convincing evidence that her emotional problems arose out of and in the course of employment. 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 22, 1993 is affirmed.

In the Matter of the Compensation of
DAVID G. YOUNG, Claimant
WCB Case Nos. 93-06243, 93-04389, 93-04940 & 93-06242
ORDER ON REVIEW (REMANDING)
McNutt & McNutt, Claimant Attorneys
Phillip Nyburg, Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Bob Angell, Inc., requests review of Arbitrator Mongrain's order that: (1) set aside its denial of claimant's low back strain condition; and (2) upheld Liberty's denial, on behalf of Hayworth Farm, Inc., of the same condition. On review, the issue is responsibility. Reviewing for questions of law only under ORS 656.307(2), we remand.

On June 12, 1992, claimant suffered a low back strain, which Liberty accepted on behalf of Hayworth Farm. On July 23, 1992, that claim was closed by a Notice of Closure awarding temporary disability and no permanent disability.

On February 17, 1993, claimant suffered another low back strain while employed by Bob Angell. On April 6, 1993, Liberty, on behalf of Bob Angell, denied responsibility only. On April 16, 1993, Liberty, on behalf of Hayworth Farm, similarly denied responsibility only. On May 26, 1993, an order pursuant to ORS 656.307 issued designating Liberty (Bob Angell) as a paying agent. On June 2, 1993, Liberty, on behalf of Bob Angell, issued a Notice of Claim Acceptance for claimant's low back strain. (Ex. 22). That same day, Liberty (Bob Angell) submitted a "1502 form," noting that it had been designated as paying agent for the claim.

At the hearing, Liberty, on behalf of Hayworth Farm, argued that Liberty, on behalf of Bob Angell, had accepted the claim and therefore had the burden of proving that its accepted injury did not contribute independently to a worsening of claimant's condition. (Tr. at 4). The Arbitrator found that Liberty/Hayworth's acceptance was not a "pure acceptance" because "Liberty's acceptance on behalf of Bob Angell was simply a perfunctory recognition of the order designating Liberty/Bob Angell as the paying agent." (O & O p. 4).

The Arbitrator was persuaded that claimant's work incident at Bob Angell was a material contributing cause of his need for low back treatment. Consequently, the Arbitrator determined that responsibility for claimant's low back condition shifted from Liberty (Hayworth Farm) to Liberty (Bob Angell). 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).

Subsequent to the Arbitrator's decision, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). The Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility of employers under ORS 656.308(1). Thus, to establish a "new compensable injury" under ORS 656.308, Hayworth Farm must now prove that the February 17, 1993 incident was the "major contributing cause" of claimant's resultant need for treatment or disability.

Because the Arbitrator applied a "material contributing cause" test, we conclude that this claim was not analyzed under the proper legal standard. Because we review only questions of law, we must remand for additional findings and a determination of which employer is responsible when the correct rule of law is applied.[1] See ORS 656.307(2).

ORDER

The Arbitrator's decision dated August 31, 1993, as amended September 16, 1993, is vacated. This matter is remanded to Arbitrator Mongrain for further action consistent with this order. Should the Arbitrator determine that further proceedings and/or argument are necessary, the Arbitrator is authorized to make the appropriate arrangements which the Arbitrator deems will achieve substantial justice to all parties. Thereafter, the Arbitrator shall issue a final, appealable order.

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[1] Liberty, on behalf of Hayworth Farm, argues that there is no evidence to support the Arbitrator's finding about Liberty's acceptance on behalf of Bob Angell. Whether acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Since we are already remanding this matter for reconsideration concerning an application of Drews, the parties are free to present this issue to the Arbitrator for further consideration. In addressing this question, the parties may wish to address the effect, if any, the Board's holdings in Janice M. Hunt, 46 Van Natta 1145 (1994), John J. Rice, 46 Van Natta 984 (1994), and Pamela S. Cheney, 44 Van Natta 2100, on recon 44 Van Natta 2277 (1992), have on this dispute.

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
WCB Case No. 88-15666 & 89-05949
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993). The Supreme Court reversed the Court of Appeals' decision, 117 Or App 128 (1991), which affirmed our prior orders that: (1) affirmed a Director's decision finding claimant ineligible for vocational assistance, Richard A. Colclasure, 42 Van Natta 2454 (1990); and (2) declined to direct the self-insured employer to provide vocational assistance to claimant pending its appeal of a prior referee's order finding claimant eligible for vocational assistance, Richard A. Colclasure, 42 Van Natta 2574 (1990). The Court has vacated our prior orders and remanded for further proceedings.

PROCEDURAL HISTORY

This matter involves two consolidated cases. In WCB Case No. 88-15666, claimant requested a hearing to review a Director's decision finding him ineligible for vocational assistance. After the hearing, Referee Leahy issued an Opinion and Order reversing the Director's decision. Finding that claimant left work due to his compensable back injury, Referee Leahy concluded that claimant was eligible for vocational assistance. The self-insured employer filed a request for Board review.

While the request for Board review was pending, claimant filed a second hearing request to compel the employer to provide vocational assistance pending the employer's appeal of Referee Leahy's order. That hearing request was assigned WCB Case No. 89-05949. After that hearing, Referee Nichols

issued an Opinion and Order declining to order the employer to provide vocational assistance. Reasoning that vocational assistance is not a benefit that is paid directly to claimant, Referee Nichols concluded that vocational assistance is not considered "compensation" for purposes of former ORS 656.313 and, therefore, was stayed pending Board review of Referee Leahy's order. Claimant requested Board review.

Meanwhile, on Board review of Referee Leahy's order, we ruled that, in determining whether the Director's decision may be modified as an abuse of discretion, see ORS 656.283(2)(d), a referee makes a record at hearing and then determines whether the hearing record "as a whole" indicates that the Director acted (found facts, reached conclusions or applied the law) to an end or purpose not justified by, and clearly against reason and evidence. 42 Van Natta 2454 (1990). We stated that the referee does not determine how the evidence preponderates or even if there is substantial evidence to support the Director's order. On the merits, we held that, because it can reasonably be concluded from the record developed at hearing that claimant left work because of a noncompensable psychological condition, the Director did not abuse his discretion in finding that claimant was not eligible for vocational assistance. We therefore reversed Referee Leahy's order and reinstated the Director's decision. Claimant filed a petition for judicial review.

On Board review of Referee Nichols' order, we adopted and affirmed her order with the comment that, because claimant's vocational assistance did not include entitlement to "compensation payable to a claimant," his vocational assistance is not the type of compensation required to be paid pending Board review. 42 Van Natta 2574 (1990). Claimant filed a second petition for judicial review.

The Court of Appeals consolidated claimant's petitions for judicial review. In WCB Case No. 88-15666, a majority of the court, sitting en banc, affirmed our order reinstating the Director's decision, essentially agreeing with our interpretation of our review authority under ORS 656.283(2)(d). 117 Or App 128 (1991). The court stated that an error of fact cannot serve as a basis in itself for reversing the Director's decision. A majority of the court also affirmed on claimant's petition in WCB Case No. 89-05949, holding that vocational assistance is not a form of compensation which must be paid pending appeal. Id. Claimant appealed to the Supreme Court.

The Supreme Court reversed. The Court identified the legal issue for resolution as whether a referee has authority, when reviewing a Director's vocational assistance decision under ORS 656.283(2), to find facts independently before exercising that review authority. Colclasure v. Wash. County School Dist. No. 48-J, supra, 317 Or at 533. Finding nothing in the statute's text or legislative history to answer that question, the Court looked for guidance in the broader administrative law context. Reasoning that granting or denying vocational assistance under ORS 656.340 is an individual decision that depends on the facts of each individual case, the Court concluded that such cases require a more substantial hearing and decisional process. Id. at 535.

Noting that the Director developed no evidentiary record and held no evidentiary hearing in concluding that claimant was not eligible for vocational assistance, the Court stated that the Director's procedure did not comply with the aforementioned process, while the referee's hearing did. Id. The Court further stated that had the Director conducted a contested case hearing, made a record, and entered findings of fact thereon, a different ruling would have been obtained. Id. at 535 n 4.

The Court concluded that use of the Director's decision in the manner approved by the Board and Court of Appeals was contrary to fundamental principles of administrative law. Consequently, the Court construed ORS 656.283 to contemplate the following process: (1) the Director informally investigates and issues an order; (2) the referee conducts a hearing at which the parties develop a record; (3) based on that record, the referee finds the facts from which to conclude whether, among other things, the Director's decision survives review; and (4) the Board reviews under ORS 656.283(2) upon the record developed before the referee. Id. at 537.

Accordingly, the Court vacated our prior orders and remanded for further proceedings consistent with its opinion. While not specifically addressing the merits of claimant's petition in WCB Case No. 89-05949, the Court also remanded that consolidated petition for further proceedings. Id. at 537 n 7.

PRELIMINARY MATTERS

On remand, the Department of Justice, on behalf of the Department of Consumer and Business Services (formerly the Department of Insurance and Finance) (hereinafter called "the Department"), has

filed a motion to intervene in this matter. The Department requests a hearing and moves to be joined as a party, alleging a pecuniary and administrative interest in the outcome of this proceeding.

We have granted the parties and the Department an opportunity to submit supplemental briefs regarding the Department's motion and the issues raised by the Supreme Court's decision. The parties and the Department have filed supplemental briefs.

Motion to Intervene

The Department asserts that it has a significant pecuniary interest in this case because it is responsible for the payment of vocational costs in all claims originating before 1986. Claimant was injured in 1982. The Department also asserts that the legislature has given it significant regulatory responsibilities in vocational assistance matters. For those reasons, the Department contends that it has standing to appear in this matter, citing Trojan Concrete v. Tallant, 107 Or App 429, rev den 312 Or 151 (1991).[1]

The Department is required to reimburse carriers for vocational assistance costs incurred for industrial injuries occurring before 1986. See OAR 436-120-220. The Department is also required to regulate the provision of vocational assistance to injured workers. See generally ORS 656.340. Indeed, this adjudication is a review of the Director's decision denying vocational assistance.

We conclude that the Department's regulatory responsibilities and pecuniary interest in the outcome of this case are sufficient to support its standing as a party to this proceeding. See Kelsey v. Department of Consumer and Business Services, 128 Or App 53, 58 (May 18, 1994); Trojan Concrete v. Tallant, supra. Accordingly, the Department's motion to intervene in this case is granted.

Motion for Remand

Under cover letter dated November 5, 1993, the Department has submitted to the Board a packet of exhibits which it represents to be the evidentiary record developed before the Director and considered by the Director in reaching his decision. Inasmuch as we are without authority to consider evidence not admitted into the record developed at the hearings in this matter, we treat the Department's submission as a motion for remand to the Referee for the taking of additional evidence. See Elizabeth S. Fields, 45 Van Natta 301 (1993); Judy A. Britton, 37 Van Natta 1262 (1985).

Under ORS 656.295(5), we have authority to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). Additionally, there must be "good cause" or some other compelling basis for remand. See Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986).

Neither claimant nor the employer join in the Department's motion for remand. Further, all of the evidence submitted by the Department was in existence and available to the parties before the hearing. Under these circumstances, therefore, we find no compelling basis for remand. See id.

The Department argues that the submission is necessary to clear up the "misunderstanding" that a record had not been developed before the Director in this matter. However, the Board, in exercising its de novo review, expressly found that the Director made no evidentiary record. Richard A. Colclasure, 42 Van Natta 2454, 2455 (1990). That finding formed the basis for the Supreme Court's conclusion that the Director's procedure did not comply with the hearing and decisional process required in this case. See Colclasure v. Wash. County School Dist. No. 48-J, 317 Or at 535 n 4. That conclusion, in turn, was essential to the Court's ruling that the referee makes findings of fact based upon the record developed at hearing and that the Board reviews under ORS 656.283(2) based upon the hearing record. See id. at 537.

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[1] The Department has requested oral argument before the Board. We ordinarily do not entertain oral argument. OAR 438-11-015(2). Here, through extensive briefing at several appellate levels and supplemental written arguments on remand, the parties have availed themselves of the opportunity to fully address the issues in these cases. The Department has also submitted written arguments on remand. Inasmuch as the Department's and parties' respective positions regarding these issues have been thoroughly defined, we are unpersuaded that oral argument would appreciably assist us in reaching our decision. See, e.g., Glen D. Roles, 45 Van Natta 282, 283 n 2 (1993). Consequently, the Department's request for oral argument is denied.

On remand, we are bound by the Court's final judgment and decline to take any action inconsistent with its opinion. Inasmuch as our finding that the Director did not develop an evidentiary record was essential to the Court's opinion, we shall not permit the Department to challenge that finding at this late date. Accordingly, the Department's motion for remand is denied.

FINDINGS OF FACT

Claimant has a compensable claim for a back injury which occurred in August 1982 while he was performing his duties as a high school custodian. The claim was closed by Determination Order on September 6, 1984 with an award of 10 percent unscheduled permanent disability. Claimant returned to work with the modification that he not pull out bleachers. Occasionally, claimant helped other custodians pull out bleachers, though he was no longer required to do so. Claimant experienced intermittent back problems, but continued to work until March 9, 1987 when psychiatrist Dr. Paltrow took him off work. Claimant was diagnosed with an adjustment disorder and treated with psychotherapy. He was also briefly hospitalized for passive suicidal ideation.

On May 26, 1987, the employer denied claimant's claim for a psychological condition. By Stipulation and Disputed Claim Settlement dated December 15, 1987, claimant and the employer agreed that claimant's compensable back condition had aggravated, thus entitling him to an additional 10 percent unscheduled permanent disability. Claimant also agreed, in exchange for $13,500, that his claim for a psychological/stress condition "will remain in a denied status and that he will have no further right to a hearing, nor any further rights under the Oregon Workers' Compensation Act relative to that condition." The parties agreed that claimant would be referred for "whatever vocational assistance to which he is administratively entitled." Finally, the stipulation provided: "Claimant hereby acknowledges that his low back condition in conjunction with his psychological stress condition has rendered him physically incapable of performing any type of employment [for the employer]. Therefore, claimant agrees to voluntarily terminate his employment with [the employer]. . ."

Claimant subsequently applied for vocational assistance. A vocational assistance provider evaluated claimant for eligibility and concluded on March 22, 1988 that claimant was not eligible for vocational assistance. The basis for this decision was that claimant left work for reasons unrelated to his compensable injury. Claimant requested that the Director review the eligibility decision. On August 31, 1988, the Director issued an order concluding that claimant was not eligible for vocational assistance because he was not required to leave work for reasons related to the compensable injury. Claimant requested a hearing.

After an evidentiary hearing, Referee Leahy reversed the Director's decision and found claimant eligible for vocational assistance. The employer requested Board review. While its request for review was pending, the employer did not provide any vocational assistance to claimant. Claimant subsequently filed a second hearing request, asserting that the employer was required to provide vocational assistance pending its appeal. After an evidentiary hearing, Referee Nichols held that vocational assistance is not compensation that must be paid pending appeal.

CONCLUSIONS OF LAW AND OPINION

WCB Case No. 88-15666

Standard of Review

On remand in WCB Case No. 88-15666, claimant contends that we must accept those facts found by Referee Leahy that are supported by the hearing record as a whole. Otherwise, claimant argues, we would be placing vocational issues on the same footing as other disputes, effectively rendering ORS 656.283(2) meaningless. We disagree.

We find no language in the Supreme Court's Colclasure opinion that limits the Board's authority to make its own findings of fact based on the record developed before the referee. Claimant points to the Court's statement that "the Board reviews under ORS 656.283(2)." See Colclasure, supra, 317 Or at 537. However, we find that the Court was addressing the "abuse of discretion" standard for review of a Director's decision regarding vocational assistance. The Court did not purport to restrict the Board's traditional factfinding authority.

Our conclusion that we retain factfinding authority is consistent with our reasoning in Marilyn M. Guardipee, 46 Van Natta 299 (1994). There, we reviewed a Director's decision, which found the claimant was ineligible for vocational assistance, under ORS 656.283(2) based upon the record developed before the referee. After reviewing the medical and vocational evidence in the hearing record, we found that the claimant was capable of performing work that paid a wage within 20 percent of the wage earned in the claimant's regular work. Based on that finding, we concluded that the Director did not abuse his discretion in finding that claimant did not have a substantial handicap to employment and, therefore, was not eligible for vocational assistance.

Here, in accordance with the Court's mandate, we conclude that our authority in reviewing this vocational assistance matter is to make independent findings of fact based on the record developed before Referee Leahy and, based on those findings, determine whether or not the Director's decision may be modified under ORS 656.283(2).

The Director's decision regarding vocational assistance may be modified under ORS 656.283(2) only if it:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

Eligibility for Vocational Assistance

The Director concluded that claimant was not eligible for vocational assistance because he left suitable employment with the employer for reasons unrelated to his compensable back injury. See OAR 436-120-050(3). Claimant contends that he left employment due to his compensable back condition and, therefore, the Director's decision is in violation of the Director's own rule, OAR 436-120-040,[2] and is an abuse of discretion.

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[2] OAR 436-120-040 provides, in pertinent part:

"A worker is eligible for vocational assistance when all of the following conditions have been met:

"(1) The worker has sustained an accepted disabling compensable injury.

"(2) There is medical evidence which indicates that, because of the injury, the worker will likely have a permanent disability; or, the worker has a Determination Order, Order of a Referee, Order on Review by the Workers' Compensation Board, decision of the Court of Appeals or an approved stipulation which grants permanent disability.

"(3) As a result of the limitations caused by the injury, the worker:

"(a) Is not able to return to regular work or other customary work;

"(b) Is not able to return to any other suitable and available work with the employer; and

"(c) Has a substantial handicap to employment and requires assistance to overcome that handicap.

"(4) The worker is not limited by personal, psychological or physical problems which would materially interfere with the worker's ability to participate in or benefit from vocational assistance.

"* * * *

"(7) None of the conditions under OAR 436-120-050 for end of eligibility:

"(a) Applies under the current opening of the claim." (Emphasis supplied).

OAR 436-120-050 provides, in pertinent part:

"The eligibility of a worker for vocational assistance ends when any of the following conditions have occurred:

"* * * *

"(3) The worker's suitable employment after the injury or aggravation ended for a reason unrelated to the injury." (Emphasis supplied).

The dispositive issue in WCB Case No. 88-15666 is whether claimant left employment for a reason related to the compensable back injury. If he did, he is eligible for vocational assistance under OAR 436-120-040. See Colclasure, 317 Or at 535.

Claimant argues that he left his job with the employer because of a combination of his compensable back condition and noncompensable psychological stress. He relies on the December 1987 stipulation, which states: "Claimant hereby acknowledges that his low back condition in conjunction with his psychological stress condition has rendered him physically incapable of performing any type of employment [for the employer]. Therefore, claimant agrees to voluntarily terminate his employment with [the employer]." (Ex. 27-5).

Hence, the parties expressly agreed that claimant left employment due to the "combination" of his compensable back condition and the noncompensable psychological stress condition. The parties further agreed that claimant was physically unable to perform any job for the employer.

The terms of the parties' stipulation are binding. See Evans v. Rookard, Inc., 85 Or App 213, 214 (1987); Timothy W. Fletcher, 43 Van Natta 1359, 1361 (1991), aff'd mem Asplundh Tree Service v. Fletcher, 110 Or App 634 (1992). The stipulation is a negotiated, signed, meeting of the minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party; when approved by the referee, it has the finality and effect of a judgment. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993); International Paper Co. v. Pearson, 106 Or App 121 (1991).

The December 1987 stipulation was approved by a referee and, therefore, binds the employer to its terms. Under those terms, we find that claimant was unable to continue working for the employer due, at least in material part, to his compensable back condition. We conclude, therefore, that suitable employment with the employer ended for a reason related to the compensable injury. Accordingly, claimant is eligible for vocational assistance under the criteria set forth in OAR 436-120-040.

We conclude that the Director's decision denying vocational assistance was in violation of OAR 436-120-040. Furthermore, given the binding terms of the parties' December 1987 stipulation, we find that the Director exercised discretion to an end not justified by this record or the rules. Accordingly, we find that the Director abused his discretion. See Bouvier's Law Dictionary; see, e.g., Farwest Landscaping v. Modern Merchandising, 207 Or 653, 664 (1979); Port of Umatilla v. Richmond, 212 Or 596 (1958); Casciato v. OLCC, 181 Or 707 (1947).

Claimant has finally prevailed after remand with respect to his eligibility for vocational assistance. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). Inasmuch as we are affirming the Referee's order, which awarded claimant's attorney an out-of-compensation attorney fee for services at hearing, it is unnecessary to address claimant's entitlement to an attorney fee for services at the hearing level. Thus, we proceed to address claimant's entitlement to an attorney fee at the Board and court levels.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at the appellate levels regarding his eligibility for vocational assistance is $4,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented byt he record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration of our October 30, 1990 order, we affirm Referee Leahy's January 18, 1989 order finding claimant eligible for vocational assistance. Claimant's attorney is awarded as assessed attorney fee of $4,000 attorney fee, payable by the employer, for services rendered on review at the Board and court levels.

WCB Case No. 89-05949

On remand, claimant contends that he was entitled to the provision of vocational assistance pending the employer's appeal of Referee Leahy's order. Claimant also contends that he is entitled to penalties and attorney fees for the employer's allegedly unreasonable refusal to provide vocational assistance.

After reviewing claimant's contentions, we conclude that our prior order adequately addresses those contentions. Accordingly, on reconsideration, we adhere to and republish our November 14, 1990 order which affirmed and adopted, with supplementation, Referee Nichols' order dated August 11, 1989.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUCKY L. GAY, Claimant
WCB Case No. 93-01603
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Daughtry's order which: (1) upheld the insurer's denial of claimant's current medical treatment for an accepted bilateral carpal tunnel and thoracic outlet claim; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but offer the following brief summary of the relevant facts.

In 1988, claimant sustained a compensable injury involving bilateral carpal tunnel and thoracic outlet syndromes. In September 1992, claimant was injured in an off-the-job motor vehicle accident. Prior to the accident, claimant experienced daily neck, shoulder, arm, hand, low and mid-back pain, as well as numbness in the shoulder, arms, hands and fingers. Claimant also suffered from headaches.

After the motor vehicle accident, claimant experienced no new symptoms, but the severity of his complaints increased. Claimant sustained one month of temporary disability and received physical therapy at the direction of his attending physician, Dr. Lafrance, a neurologist. Dr. Lafrance diagnosed cervical, trapezial, and lumbar strain "induced by" a motor vehicle accident superimposed upon a chronic and severe degenerative disc disease. (Ex. 42). In subsequent reports, Dr. Lafrance diagnosed a pain exacerbation "due to" a motor vehicle accident. (Exs. 46-3, 46-4).

Based on these reports, the insurer issued a denial on December 23, 1992 of claimant's "current treatment for cervical, trapezial, lumbar strain, thoracic outlet syndrome, carpal tunnel syndrome, and bilateral numbness in both hands." (Ex. 48). The denial also recited that Dr. Lafrance had stated that claimant's "current need for treatment and disability is not the injury on June 22, 1988 but your car accident September, 1992."

On February 19, 1993, Dr. Lafrance opined that the 1988 injury remains the major contributing cause of claimant's various conditions. (Ex. 51). He described the contribution of the motor vehicle accident as "small." However, in his deposition, Dr. Lafrance clarified his opinion.

Dr. Lafrance testified that the motor vehicle accident was the major contributing cause of claimant's need for treatment and disability after the September 1992 automobile accident to March 5, 1993, when the compensable injury resumed being the major causal factor. (Exs. 52-33, 52-47). Dr. Lafrance confirmed that at all times the compensable 1988 injury was at least a "material contributing cause" of claimant's need for treatment. (Ex. 52-45).

CONCLUSIONS OF LAW AND OPINION

Compensability

At hearing, the insurer construed its denial as one of medical treatment. (Tr. 1). Claimant considered the denial to be of his current condition. (Tr. 1). Claimant expressly denied that he was asserting an aggravation claim. (Tr. 5). The Referee, however, analyzed the case as an aggravation

claim. Specifically, the Referee stated the issue was whether the intervening automobile accident was the major contributing cause of claimant's worsened condition prior to the denial. See ORS 656.273(1). Finding Dr. Lafrance's opinion to well-reasoned, the Referee concluded that the motor vehicle accident was the major contributing cause of claimant's worsened condition. Consequently, the Referee upheld the insurer's denial.

Claimant initially contends that the Referee erred in applying an aggravation analysis to a medical-treatment question under ORS 656.245. Subsequent to the Referee's order, in Nikki Burbach, 46 Van Natta 265, 268 (1994), we held that a referee's review is limited to issues raised by the parties. Here, the parties interpreted the insurer's denial somewhat differently. However, claimant expressly stated that he was not asserting an aggravation claim. The insurer did not raise an issue of aggravation, either. Nevertheless, the Referee applied ORS 656.273(1) in approving the insurer's denial. Inasmuch as an aggravation issue was not presented for resolution, the Referee erred in addressing such an issue. See Nikki Burbach, supra; Dave E. Herman, 44 Van Natta 469, 470 (1992). Thus, we do not consider what affect, if any, ORS 656.273(1) has on this claim.

Citing Beck v. James River Corporation, 124 Or App 484 (1993), claimant contends that his medical treatment is compensable, even during the period in which the intervening motor vehicle accident was the major contributing cause of his need for treatment. We agree.

In Beck, the claimant suffered an exacerbation of a compensable shoulder condition as a result of undergoing an EMG test for an unrelated neck condition. Claimant did not seek compensation for a new injury or condition. The EMG merely caused a need for treatment of the compensable shoulder condition. The Board held that the "major contributing cause" standard of ORS 656.005(7)(a)(A) applied to a claim for medical services. We upheld the employer's denial after determining that claimant failed to sustain her burden of proof.

The court reversed. It held that medical services for conditions resulting from the injury are compensable if the need for treatment bears a material relationship to the compensable condition. Beck v. James River Corp., 124 Or App at 487. Analogizing the diagnostic EMG in Beck to the the noncompensable fall at home in Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 OR 528 (1993), the court emphasized that both were unrelated events that intervened to require further treatment of the compensable condition. That treatment, according to the court, is compensable if it is materially related to the compensable condition. Beck, supra at 488.

Here, the intervening, noncompensable motor vehicle accident is likewise analogous to the diagnostic EMG in Beck and the fall at home in Ferguson. Like those events, the car accident in this case has also intervened to cause a need for treatment for claimant's compensable condition resulting from the accepted 1988 claim. Claimant seeks no compensation for a new injury or condition. Although no party argues that ORS 656.005(7)(a)(A) is applicable, the issue is the same as it was in Beck and in Ferguson: that is, whether claimant's medical treatment is materially related to the compensable condition. Based on Dr. Lafrance's uncontradicted medical opinion, we find that it is. Thus, we reverse the Referee's decision upholding the insurer's denial and set aside the denial of claimant's medical treatment.

Penalties and Attorney Fees

Claimant also contends that the insurer's denial was unreasonable. The Referee did not reach this issue because he had upheld the denial and considered the issue to be moot. Given our finding that the insurer's denial was improper, we reach the issue. However, do not consider the denial to have been unreasonably issued.

A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the insurer at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Continuation of a denial in the light of new medical information becomes unreasonable only if the new evidence destroys any legitimate doubt about the insurer's liability. See id. at 592.

Claimant contends that the insurer's denial was based on a false statement and, therefore, was unreasonable. Specifically, claimant asserts that Dr. Lafrance never said that claimant's need for treatment was due to the September 1992 motor vehicle accident instead of the September 1988 injury.

We disagree with claimant's contention. The insurer could legitimately have interpreted Dr. Lafrance's medical reports issued prior to the denial as stating that claimant's need for treatment was due to the motor vehicle accident. Dr. Lafrance stated that claimant's exacerbation was "due to" the motor vehicle accident and that his condition was "induced by" the intervening injury. While Dr. Lafrance did not use the exact phrasing recited in the denial letter, the insurer could legitimately infer the basis for its denial from his medical reports.

Moreover, the insurer's legitimate doubt continued after its denial. We agree with the Referee that the insurer's denial referred to the period of the exacerbation of claimant's compensable condition caused by the motor vehicle accident. Dr. Lafrance testified that the motor vehicle accident was the major contributing cause of claimant's need for treatment during this period. The insurer continued to have a reasonable belief it was not responsible for claimant's medical treatment when the treating physician attributed his treatment in major part to the noncompensable accident.

Claimant's counsel is entitled to attorney fees for services at hearing and on review concerning 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 regarding the denial issue is $3,000, to be paid by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 14, 1993 is reversed in part and affirmed in part. That portion which upheld the insurer's denial of claimant's medical services claim is reversed. The insurer's December 23, 1992 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by the insurer.

In the Matter of the Compensation of
LLOYD S. HEESE, Claimant
WCB Case No. 93-02941
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Daughtry's order that set aside its denial of claimant's aggravation claim for an L3-4 disc herniation. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

To establish a compensable aggravation, claimant must prove a worsened condition resulting from a compensable injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening. Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993).

In this case, there is no dispute over the worsening element of claimant's aggravation claim. The only issue is causation. The Referee concluded that, based on the opinions of Dr. Lax, claimant's treating surgeon, claimant has carried his burden concerning the causation element of his claim. We disagree.

Before we analyze the medical evidence, we note that the parties disagree regarding the applicable legal standard. SAIF argues that, because the medical evidence establishes that claimant's preexisting degenerative condition contributed to his disc herniation, and because claimant conceded on review that he did not suffer a disc herniation in May 1990, claimant must prove that his accepted 1990 low back strain is the major contributing cause of his disc herniation. ORS 656.005(7)(a)(B); Gray v. SAIF, supra. In contrast, claimant argues that, under ORS 656.273(1), he need only establish that his compensable low back strain was a material contributing cause of his disc herniation. We need not resolve that issue because, for the reasons set forth below, we conclude that claimant's claim fails under either standard.

In 1990, claimant sustained a compensable low back strain. Thereafter, he experienced intermittent low back pain. In March 1992, two days after he had lifted a 20 pound picnic bench over a fence, claimant sought treatment for low back pain, which he continued to experience intermittently thereafter. One night in mid-November 1992, claimant awoke with severe left leg pain that rendered him unable to work. An MRI scan revealed an L3-4 disc herniation. In December 1992, Dr. Lax, neurosurgeon, performed an interlaminectomy and discectomy with good results. Claimant has returned to work.

Three medical experts have rendered opinions regarding the cause of claimant's L3-4 disc herniation: Dr. Lax; Dr. Dickerman, a neurologist who performed a records review; and Dr. Arbeene, examining orthopedist.

Dr. Arbeene, along with Dr. Brooks, neurologist, examined claimant in February 1993. (Ex. 15). After considering a detailed history and claimant's MRI and physical examination results, they concluded that, because claimant's left leg radicular pain had first appeared in November 1992, he probably had experienced a spontaneous disc herniation at that time. (See id. at 5). Accordingly, they concluded that claimant's L3-4 disc herniation was not related to his 1990 low back strain. (Id.)

Dr. Lax did not concur with Drs. Arbeene's and Brooks' opinion. (Ex. 17). Rather, he stated:

> "With regard to [claimant's] symptoms, I think they are fully related to the incident in 1990. In 1986 the patient was seen in the ER with muscle strain and did not have problems with back pain until 1990. In 1990 he had an incident at work which caused him back pain, and intermittently over the ensuing years he required treatment by chiropractor for low back pain. Finally in 1992 the pain exacerbated to the point that where he required surgically assistance. This clearly indicates that following the event in 1990 the patient developed a chronic low back syndrome that ultimately ended in him requiring surgery." (Ex. 18).

Subsequently, Dr. Dickerman performed a records review. (Ex. 18a). He concluded that, because claimant's records revealed that he weighed between 202 and 207 pounds, claimant was obese and possibly "out of shape." (Id. at 6-7). He also concluded that claimant had a preexisting degenerative disc condition and thoraco-lumbar scoliosis. (Id.) Finally, he noted that there was no evidence that claimant's 1990 accepted low back strain had been accompanied by any radicular symptoms. Taken together, those factors led Dr. Dickerman to conclude that claimant could have experienced a spontaneous disc herniation in November 1992, and that his disc herniation was not causally related to the 1990 low back strain. (Id. at 7).[1]

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[1] Dr. Dickerman also concluded that the March 1992 picnic bench incident constituted a new, intervening injury. In contrast, Drs. Arbeene and Brooks concluded that the incident had no impact on claimant's disc herniation. (Ex. 15-5). We agree with the Referee that the evidence does not establish that the incident was a discrete injurious event.

Dr. Lax disagreed with Dr. Dickerman's opinion. (Ex. 19). Lax stated that, although the classical presentation of disc herniation involves the acute onset of extreme low back pain over a period of days or a week that progresses to severe leg pain, some cases involve the delayed onset of radicular symptoms. (Id.) Lax then concluded that, because claimant's back problems began in 1990 with a work injury and had gradually progressed over the years to the point of requiring surgical intervention, claimant must have suffered a disc injury in 1990. (Id.)

Dr. Arbeene agreed with Dr. Lax's description of the classical case of disc herniation. (Ex. 20). However, he stated that he had never seen a patient sustain a disc herniation that did not manifest radicular symptoms until years later. (Id.) Therefore, he concluded that it was medically improbable that claimant would have sustained a disc injury in 1990 and not experience symptoms of herniation until November 1992. (Id.)

In a supplemental report, Dr. Dickerman enclosed a medical article entitled A Clinical Overview of Low Back Pain, in which the author noted a 5 percent or less incidence of chronic lumbar disc protrusion among his low back pain patients. (Ex. 21-2, -9-10). The article stated:

> "These patients tend to have a long history of episodes of back pain, some of which were severe. Patients can usually recall at least one episode when pain migrated down one leg. They recover from each episode but then begin to note an increasing frequency of recurrence, with the pain appearing more disabling, resolving less easily, and involving primarily one leg." (Id. at 9).

In his final opinion, Dr. Lax discussed the medical article, and concluded that claimant's clinical presentation matched the diagnosis of chronic lumbar disc protrusion. (Ex. 22). He said:

> "[C]laimant began with pain in 1990 which was not severe enough to require medical attention. The episodes of pain became more frequent and painful, ultimately causing him to seek treatment with a chiropractor. Finally he developed radicular symptoms. Had his anatomy been more forgiving, he would have had less pain; his surgery would have been avoided; and we would now be talking about a patient with chronic intermittent radicular symptoms." (Id. at 1).

In light of the "relentlessly progressive nature of [claimant's] pain," (id. at 2), the eventual appearance of radicular symptoms and claimant's radiographically demonstrated disc herniation, Dr. Lax concluded that claimant's 1990 low back injury clearly had caused his disc herniation. (Id.)

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

We find persuasive reasons not to defer to Dr. Lax's opinions. Dr. Lax concludes that, because claimant sustained a back strain in 1990, followed by intermittent back pain and, eventually, surgery, claimant necessarily must have experienced a disc injury in 1990. (See Exs. 18, 22). We do not find that reasoning persuasive, because it rests almost entirely on the sequential relationship between claimant's original back strain, the intervening back symptoms and his eventual disc surgery. Moreover, it fails to meaningfully address the possibility that claimant's need for surgery was the result of a spontaneous disc herniation. Because establishing a chronological relationship between two conditions is not sufficient to establish that the first caused the second, particularly in the absence of the careful elimination of an identified potential alternative cause, we afford Dr. Lax's opinions little weight. See Allie v. SAIF, 79 Or App 284, 288 (1986); see also ORS 656.266.

We also find faulty Dr. Lax's comparison of claimant's clinical history to that of patients with chronic lumbar disc protrusion. The description in the medical article on which Dr. Lax relied indicates that these patients have a history of recurrent radicular pain in one leg that occurs with increasing frequency and severity. (Ex. 21-9). In contrast, the record reveals that claimant had only one episode of radicular pain (the November 20, 1990 exacerbation) before he had his surgery. That alone distinguishes claimant from the profile of persons with chronic lumbar disc protrusion. Furthermore, Dr. Lax's statement that, had claimant been able to avoid surgery, he would have displayed chronic intermittent radicular symptoms, is speculative. For these reasons, we are not persuaded by Dr. Lax's conclusion that claimant had chronic lumbar disc protrusion.

For the foregoing reasons, we give Dr. Lax's opinions minimal probative weight.

We find Dr. Dickerman's opinions unpersuasive for two reasons. First, he never saw claimant. See Mary A. Haile, 45 Van Natta 2163 (1993) (medical opinion based on reviewing records usually not persuasive). More importantly, his opinion is, in large part, based on the presumption that claimant was obese and "out of shape." (See Ex. 18a-6, -7). Evidently based on his personal observation of claimant, the Referee found that claimant was not obese. We do not disturb that finding. In light of that finding, and the fact that nothing in the record indicates that claimant was "out of shape," we afford Dr. Dickerman's opinions minimal weight. See Somers v. SAIF, supra.

That leaves Dr. Arbeene's opinions. We find no reasons to discount his reports. He personally examined claimant and obtained a very detailed and accurate history of claimant's back problems. Based on that history and the physical examination and a review of claimant's MRI, Dr. Arbeene persuasively reasoned that, in light of his clinical experience, it was medically improbable that claimant would have sustained a disc injury in 1990, but not manifest radicular symptoms until over two years later. Therefore, we rely on his conclusion that claimant's L3-4 disc herniation was not caused by his 1990 low back strain.

For the foregoing reasons, we conclude that claimant has failed to establish a causal connection between his L3-4 disc herniation and his compensable low back strain. Accordingly, claimant's L3-4 disc herniation is not compensable.

ORDER

The Referee's order dated October 18, 1993 is reversed. The SAIF Corporation's denial is reinstated and affirmed in its entirety. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
MICHAEL J. JOSEPH, Claimant
WCB Case Nos. 93-00044, 92-02820, 93-07404, 93-07405, 92-15447, 93-07407, 92-14801, 93-07402, 92-07383, 93-07401, 92-07305, 93-07406, 92-03952, 93-07400, 92-05060, 93-07403, 92-01444 & 93-07399
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Marcia Barton (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Moscato, et al., Defense Attorneys
Stoel, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys
Wallace & Klor, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation, on behalf of Al Beyer Logging (Beyer/SAIF), requests review of those portions of Arbitrator Livesley's order which: (1) set aside its responsibility denials for claimant's bilateral knee conditions; and (2) awarded claimant's counsel an attorney fee pursuant to ORS 656.307(5), to be paid by Beyer/SAIF. In its appellant's brief, Beyer/SAIF contends that the Board's review is de novo because the proceeding was not an arbitration pursuant to ORS 656.307. On review, the issues are standard of review, responsibility and attorney fees. We remand.

FINDINGS OF FACT

We adopt the Arbitrator's findings of fact, with the following correction. The fifth finding on page 7 of the Referee's order is corrected to read: "Claimant presented August 14, 1989, with complaints of right side giveway with anterior pain after a hike of 8 miles."

We do not adopt the Arbitrator's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

The Arbitrator found Beyer/SAIF responsible for claimant's bilateral knee conditions. Beyer/SAIF requested review. As a threshold issue, Beyer/SAIF contends that the appropriate standard of review by the Board is de novo, because the proceeding before the Arbitrator was not an arbitration pursuant to ORS 656.307. We disagree.

ORS 656.307 provides that when there is an issue of responsibility for payment of compensation for two or more injuries, and the employers and insurers admit the claim is otherwise compensable, the Director shall issue a "307" order designating a paying agent. ORS 656.307(1)(c). The Director shall then ask the Board to appoint a referee to act as an arbitrator to determine the responsible paying party. With one exception, the Arbitrator's order is subject to review for questions of law only. ORS 656.307(2).

On review, Beyer/SAIF contends that because the Director issued a "307" order after the hearing, the proceeding before the Arbitrator could not have been a "307" arbitration. We disagree.

The hearing was held on March 1, 1993. None of the parties raised compensability as an issue at the hearing. (See Tr. 1-12). Following the hearing, the Arbitrator advised the Director to proceed with issuing the "307" order, which claimant had requested in December 1992. The hearing record remained open for receipt of additional documents, including the "307" order, and written closing arguments. Both claimant and Weyerhaeuser submitted the "307" order once it issued on June 9, 1993, and it was received in evidence as Exhibit 159. Thereafter, the record closed on July 18, 1993.

Beyer/SAIF did not object to admission of the "307" order, nor did it object to the issuance of the order. It first objected to the characterization of the proceeding as an arbitration in its appellant's brief. However, even on review, Beyer/SAIF does not assert that compensability is an issue. Instead, it simply contends that the Board's review should be de novo, rather than limited to questions of law.

Under these circumstances, we find the proceeding was properly characterized as an arbitration under ORS 656.307. Although the hearing began before the "307" order issued, issues may be amended during a hearing when the evidence supports an issue not previously raised. OAR 438-06-031. We find that is in effect what occurred here when the parties submitted the "307" order, and it was admitted into evidence without objection. Under the circumstances of this case, we find that the parties effectively agreed to a "307" arbitration during the hearing process.

A party that is surprised or prejudiced by an amendment of issues during the hearing may request a continuance. OAR 438-06-031. However, no party objected to admission of the "307" order, nor did any party claim surprise or prejudice when the "arbitrator's" order issued. Accordingly, since the sole issue was and remains responsibility, a "307" order issued while the matter was pending before the Hearings Division, and no party has claimed it was surprised or prejudiced, we find no error in characterizing this proceeding as an arbitration under ORS 656.307.

Our review of an arbitrator's order is confined to questions of law, with one exception. "[I]f the claimant can establish, on the arbitration record, that the determination resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator . . . shall be as provided for matters concerning a claim." ORS 656.307(2).

Here, claimant did not appeal the Arbitrator's order, but instead argued that it should be affirmed. Accordingly, the exception in ORS 656.307(2) allowing de novo review of an Arbitrator's decision does not apply in this case. See Darrell W. Vinson, 46 Van Natta 377 (1994); John L. Riggs, III, 42 Van Natta 2816 (1990); compare Shelley C. Nikolaus, 46 Van Natta 458 (1994) (claimant appealed arbitrator's responsibility assignment, demonstrating that different assignment will affect temporary disability rate).

Accordingly, our review is confined to questions of law. ORS 656.307(2); John L. Riggs, III, supra; Darrell W. Vinson, supra.

Responsibility/Remand

Responsibility for claimant's left knee condition shifted to Gary Kronberger Cutting, insured by SAIF (Kronberger/SAIF), after litigation in 1989. On October 25, 1991, Kronberger/SAIF reopened the claim for left knee chondromalacia following the treating physician's request for surgery. (Ex. 100). The left knee claim was closed in 1992. Thereafter, on February 9, 1993, Kronberger/SAIF revoked its October 25, 1991 reopening pursuant to ORS 656.262(6), and denied responsibility for the left knee condition. (Ex. 154).

Although the insurer characterized its action as a "back-up" denial under ORS 656.262(6), the Arbitrator disagreed. Instead, he treated the February 9, 1993 denial as simply one of responsibility, reasoning that a "back-up" denial of a reopening is unnecessary where a claimant has filed claims against subsequent employers, seeking to establish a "new injury." We disagree.

A "back-up" denial is a retroactive denial of a previously accepted claim. Oak Crest Care Center v. Bond, 101 Or App 15, 17, n 1 (1990). That is what occurred here. (See Ex. 154). Like "back-up" denials of compensability, "back-up" denials of responsibility are prohibited, except under the circumstances set forth in ORS 656.262(6). See Ebbtide Enterprises v. Tucker, 303 Or 459, 463 (1987). Accordingly, Kronberger/SAIF's denial must be evaluated under the standards set forth in ORS 656.262(6). See e.g., Darwin G. Widmar, 46 Van Natta 1018 (1994) (ORS 656.262(6) expressly limits "back-up" responsibility denials to those issued by a "paying agent" appointed under ORS 656.307).

Because the Arbitrator did not evaluate Kronberger/SAIF's February 9, 1993 "back-up" denial of responsibility under ORS 656.262(6), the Arbitrator's order is inconsistent with applicable law. Accordingly, because our review is limited to questions of law, we remand this matter to the Arbitrator for proper application of law. ORS 656.307(2).

Inasmuch as we are remanding the Arbitrator's order, we do not reach the attorney fee issue, nor do we address the issue of responsibility for the right knee condition. Because we are returning this case to the Hearings Division, the parties may present their arguments on these and other issues raised on review to the Arbitrator.

ORDER

The Arbitrator's order dated August 10, 1993 is vacated. This matter is remanded to Arbitrator Livesley for a determination of the responsible carrier or carriers. Arbitrator Livesley may make that determination with or without further proceedings in any manner that will achieve substantial justice. Thereafter, the Arbitrator shall issue a final, appealable order.

In the Matter of the Compensation of
DONALD E. BECK, Claimant
WCB Case No. 91-01904
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Wallace & Klor, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Beck v. James River Corporation, 124 Or App 484 (1993). The court has reversed our prior order, Donald E. Beck, 45 Van Natta 179 (1993), that applied ORS 656.005(7)(a)(A) and held that a medical services claim for claimant's left shoulder was not compensable because the 1986 compensable left shoulder injury was not the major contributing cause of the need for medical services. Reasoning that ORS 656.005(7)(a)(A) was not applicable to claimant's medical services claim, the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the findings of fact as recited in our prior order.

CONCLUSIONS OF LAW AND OPINION

In 1983, claimant injured his left shoulder in a noncompensable motorcycle accident. In April 1986, claimant sustained a compensable left shoulder injury and eventually received a permanent 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 which resulted in the need for medical treatment. Claimant sought payment for this medical treatment under his 1986 left shoulder claim. The self-insured employer denied that the medical treatment was compensable.

Claimant requested a hearing. The Referee found that the medical services were not compensable because the worsening of claimant's left shoulder condition was caused in major part by an injury not occurring in the course and scope of employment. Claimant requested Board review.

Although applying a different analysis than that applied by the Referee, we affirmed the Referee's order. Analyzing claimant's claim for medical services as a "consequential condition" under ORS 656.005(7)(a)(A), we held that the treatment was not compensable because claimant's compensable left shoulder injury was not the major contributing cause of the need for medical services.

Claimant petitioned for judicial review of our order. The Court of Appeals reversed our decision. Beck v. James River Corporation, supra. Reasoning that the EMG merely caused a need for further treatment of the compensable shoulder condition (rather than causing a new injury or condition), the court held that ORS 656.005(7)(a)(A) was not applicable. Instead, relying on Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 528 (1993), the court determined that the left shoulder treatment was compensable if the need for treatment was materially related to the compensable condition.

Consequently, the court has remanded with instructions to determine whether the need for medical services bears a material relationship to the compensable injury. In accordance with the court's mandate, we proceed with our reconsideration.

Dr. Davis, M.D., treated claimant following his 1986 compensable left shoulder injury. Claimant returned to Dr. Davis in November 1990 with complaints of "knots" in his neck, pain down his left arm, and limited cervical motion. Dr. Davis opined that these symptoms were probably coming from a neck problem that was probably caused by degenerative disc disease or pressure on a nerve. Dr. Davis referred claimant to a neurologist who performed an EMG in an effort to diagnose the neck problem.

In January 1991, claimant returned to Dr. Davis complaining of left shoulder pain. At his deposition, Dr. Davis was first informed about claimant's 1983 noncompensable left shoulder injury. After receiving this information, Dr. Davis opined that the combination of the EMG and claimant's prior left shoulder injuries caused the flare-up of claimant's left shoulder symptoms and resulting need for treatment. (Exs. 48-29, -42). Dr. Davis concluded that both injuries, not the EMG, were the primary cause of the flare-up in claimant's left shoulder. (Ex. 48-29).

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 defer to Dr. Davis. He treated claimant following the 1986 compensable injury and is in the best position to judge whether claimant's current need for treatment is related to that injury.

Inasmuch as Dr. Davis attributes claimant's need for left shoulder treatment to both the 1983 noncompensable injury and the 1986 compensable injury, we find that such an opinion establishes that the compensable 1986 left shoulder injury is a material contributing cause of the need for treatment of the left shoulder following the EMG. Thus, claimant has established the compensability of the medical services related to the left shoulder following the EMG.

Claimant has finally prevailed after remand with respect to his medical services claim. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991).

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, the Board, and the court levels regarding the medical services 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 the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration of our February 9, 1993 order, the Referee's order dated April 30, 1992 is reversed. The self-insured employer's denial insofar as it related to the left shoulder is set aside. The claim is remanded to the employer for processing in accordance with law. Claimant's attorney shall receive a $4,000 attorney fee, payable by the self-insured employer, for services rendered at hearing and on review at the Board and court.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARTHUR BIEBER, Claimant
WCB Case No. 93-06988
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Westerband, Haynes and Gunn.

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

We adopt and affirm the Referee's order.

ORDER

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

Board Member Gunn dissenting:

Perhaps because I am a middle-aged male, I do not easily adopt medical opinions that assign "idiopathic" causes to occupational diseases merely because the worker is a middle-aged male. I am even less likely to buy this medical dribble in the face of a treating doctor's opinion to the contrary.

"Idiopathic," as a description and diagnosis, only confirms what the medical practitioner does not know--the actual cause of the condition. The fact that our bodies malfunction as we age and degenerate is no mystery. Thus (and alas), almost any medical condition will occur more frequently in the population as it reaches mid-life. As a quaint bumper sticker puts it, "A good day is when I wake up and something new isn't hurting."

The question before me as a finder of fact is to determine which medical opinion is more reasoned and persuasive. In the instant case, I am faced with three opinions, and I would assign deference to the treating physician who attributes claimant's condition to work activities. One of the other physicians, after a one-time-only exam, attributes claimant's condition to ideopathic causes. A third doctor, after a mere review of the medical records, confirmed the idiopathic diagnosis, and attributed CTS to middle-aged persons, a diagnosis supported only by the doctor's assertion.

Given the above, I find no persuasive reasons not to defer to the treating physician. Indeed, a condition attributed to unknown causes, or simply to the journey we all take to becoming worm food, is not compelling or reasonable. Further, even if that journey were a cause, I would find aging to be a predisposition we all suffer, hopefully for a goodly measure of time.

For those reasons, I respectfully dissent.

In the Matter of the Compensation of
KENNETH R. BULLION, Claimant
WCB Case No. 93-05233
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Referee Livesley's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. The employer contends that the Referee erred by excluding a report from its examining physician. Claimant cross-requests review, arguing that the Referee erred by excluding a report from his attending physician. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The employer argues that the Referee improperly excluded from the September 29, 1993 hearing an August 17, 1993 report from Dr. Nathan, a hand specialist. (Ex. 12). Claimant contends that the Referee improperly excluded a July 14, 1993 letter from Dr. Maukonen, his treating physician. (Ex. 11A). We review the Referee's evidentiary rulings for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

Exhibit 11A

Claimant's attorney claimed that he mailed a copy of the July 14, 1993 report from Dr. Maukonen to the employer's attorney on July 15, 1993. (Ex. 11A). The employer's attorney did not actually receive a copy of the report until the day of the hearing, September 29, 1993. The Referee found that there was no evidence that the July 14, 1993 report from Dr. Maukonen was actually mailed by claimant's attorney to the employer's attorney so as to give rise to the presumption of receipt.

Applying OAR 438-07-018(4), the Referee concluded that the employer had established material prejudice. The employer argued that if it had received the report in a timely manner, it would have cross-examined Dr. Maukonen or asked Dr. Nathan to comment on the report. (Tr. 27). The Referee found that claimant had not established good cause for the failure to provide the report. Claimant argues that he established a presumption of mailing and therefore, he timely disclosed the report under OAR 438-07-015.

OAR 438-07-015 requires the parties to disclose claims documents within 15 days of initial request and to disclose subsequently obtained documents within 7 days of receipt. OAR 438-07-018(4) vests the Referee with discretion to exclude documents not disclosed within the time prescribed by OAR 438-07-015, based on a determination of whether material prejudice resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party.

Claimant's failure to provide Exhibit 11A until the day of the hearing violated OAR 438-07-015(4), which provides:

> "Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents." (Emphasis added).

We conclude that the presumption of mailing does not apply because the rule requires that the additional documents must "be provided to the other parties," i.e., the other party must actually receive the documents. Such an interpretation is consistent with the purpose of the rule, which is to promote the full and complete disclosure of all facts and opinions. OAR 438-07-015(5). Before the other party can be expected to respond, it must actually receive the documents.

Here, it is undisputed that the employer did not receive Dr. Maukonen's report before the hearing. On September 9, 1993, the employer submitted its index of exhibits. Dr. Maukonen's July 14, 1993 report was not contained on that list. The Referee found that claimant's counsel's firm was provided with the list on September 9, 1993. Nevertheless, claimant did not introduce the report until the September 29, 1993 hearing, when the employer also first received its copy of the report.

The Referee found that the employer had suffered prejudice and that claimant had not established good cause for the failure to timely disclose the document. Claimant's counsel's reason for not disclosing the exhibit after receiving the employer's index of exhibits on September 9, 1993 was that he was away from the office until September 27, 1993. We do not consider such an explanation as good cause for the delay. See Donald R. Dodgin, 45 Van Natta 1642 (1993) (claimant's reasons of inadvertence and his attorney's belief that the insurer already had a copy of a document did not constitute good cause for untimely disclosure of the document). Accordingly, we conclude that the Referee did not abuse his discretion in refusing to admit Exhibit 11A.

Exhibit 12

The Referee found that Exhibit 12 (an August 17, 1993 report from Dr. Nathan) was received by the employer August 20, 1993 and disclosed to claimant on September 9, 1993, (when the employer submitted its index of exhibits), a period exceeding 7 days. See OAR 438-07-015. The Referee reasoned that claimant had established material prejudice because there were no other medical reports stating that his claim was not compensable. The Referee concluded that the employer had no reason for its failure to disclose and therefore, a finding of good cause outweighing prejudice was not possible. See OAR 438-07-018(4).

The employer argues that the Referee erred in concluding that claimant suffered material prejudice from the delayed disclosure. The employer contends that because it timely disclosed Exhibit 12 within 20 days of the scheduled hearing, see OAR 438-07-018, claimant had sufficient time in advance of hearing to request cross-examination or to otherwise rebut the evidence.

OAR 438-07-015(4) provides that the documents "shall be provided to the other parties" within seven days after receipt (Emphasis added). The employer did not comply with this rule and it offers no excuse for its failure to do so. The fact that the employer complied with OAR 438-07-018(1) by submitting the exhibit 20 days before the hearing does not cure the fact that it did not comply with OAR 438-07-015(4). OAR 438-07-018(4) provides the Referee with the discretion to deny admission of documents not disclosed as required by OAR 438-07-015. We conclude that the Referee did not abuse his discretion in refusing to admit Exhibit 12.

Compensability

We adopt and affirm the portion of the Referee's order regarding compensability.

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

ORDER

The Referee's order dated October 26, 1993 is affirmed. for services on review, claimant's attorney is awarded $750, payable by the self-insured employer.

In the Matter of the Compensation of
CLINTON C. BUZZARD, Claimant
WCB Case No. 93-02257
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On June 2, 1994, we withdrew our May 12, 1994 Order on Review which: (1) set aside the self-insured employer's denial of claimant's current low back condition; and (2) awarded a carrier-paid attorney fee of $5,000. We took this action to consider the employer'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, the employer did not submit a timely response to claimant's counsel's request for an attorney fee award. Thus, insofar as the employer's motion for reconsideration contains specific objections to claimant's counsel's petition for an assessed attorney fee, those objections shall not be considered. See OAR 438-15-029(4); Anthony Foster, 45 Van Natta 1997 (1993). However, inasmuch as the employer has timely requested reconsideration of a portion of our order, we have chosen to proceed with a reconsideration of our decision.

As noted in our prior order, 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 issues(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 82 exhibits, two of which were generated by claimant. There were no depositions. The transcript of the hearing involved one lay witness and 74 pages.

On Board review, claimant's counsel submitted an opening brief (7 pages) and a reply brief (5 pages), and provided a thorough argument regarding claimant's contention that his current condition was related to his 1986 compensable low back injury. Submitting a statement totalling 22 hours of attorney time for an attorney with many years' experience, and 12 hours of attorney time on review for an attorney with two years' experience, claimant sought an attorney fee of $8,400.

We draw the following conclusions from the foregoing findings. The value of this compensability issue is substantial in that claimant requires surgery for a disc herniation, and claimant will be receiving treatment and potentially temporary and permanent disability.

The issues in dispute involved medical matters of normal complexity (opinions from four physicians) consistent with compensability disputes that are generally presented for Board resolution. The events which transpired at the hearing level and on review are consistent with those which normally arise when the Board confronts a compensability dispute regarding a medical issue. Claimant argued one theory of compensability at hearing. On Board review, claimant raised additional theories which were not addressed. Finally, there was a risk that counsel's efforts might have gone uncompensated.[1]

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 $4,000. Consequently, we reduce our attorney fee award from $5,000 to $4,000. In reaching this conclusion, we have also taken into consideration that claimant's attorney will receive 25 percent of claimant's temporary disability, not to exceed $1,050, which has been granted under the Own Motion order.

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[1] Because claimant did not address "Frivolous defenses/issues" as a factor in his original statement of services, it is too late to consider at this time. In any event, we do not consider the employer's motion for reconsideration to be frivolous.

Accordingly, we republish our May 12, 1994 order with the following modification. In lieu of our prior attorney fee award, claimant's attorney is awarded $4,000 for services at hearing and on review, to be paid by the self-insured employer. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Haynes concurring.

I continue to believe that the claim is not compensable. However, since the majority of my fellow members has found the claim compensable, I am obligated to follow that finding. For the reasons expressed in this opinion, as well as those given in my prior dissenting opinion, I find that $4,000 is an imminently reasonable attorney fee award in this case.

Board Member Hall dissenting.

The amount of claimant's attorney fee was the subject of debate when we issued our Order on Review. I see no reason to second-guess ourselves at this time. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
REX A. HOWARD, Claimant
WCB Case No. 92-15911
0RDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of Referee Tenenbaum's order finding valid a 1987 Determination Order and its medically stationary date. On review, the issue is the effect of the 1987 Determination Order for purposes of determining claimant's aggravation rights.

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

In 1985, claimant filed an occupational disease claim for his back. The SAIF Corporation accepted lumbar and thoracic fibromyositis. In November 1987, a Determination Order issued finding claimant medically stationary November 4, 1987, and awarding temporary and permanent disability. In June 1988, SAIF denied the compensability of various conditions.

In September 1988, a hearing was held before Referee Foster. At hearing, claimant's attorney stated that all of claimant's conditions were medically stationary and asked Referee Foster to rate permanent disability. Claimant did not assert that the 1987 Determination Order prematurely closed his claim.

Referee Foster issued an order identifying "compensability" as the issue and setting aside the June 1988 denial to the extent that some of the conditions denied by SAIF were compensably related to work activity. The Referee's order also stated that the "claim will be kept open by SAIF for treatment of these conditions until closure is authorized * * *." (Ex. 15-4).

In September 1990, the Board issued an Order on Review that "reversed in part and affirmed in part" Referee Foster's order. After identifying the issue as "compensability", the Board's order reversed that portion of the Referee's order finding some conditions compensable and reinstated SAIF's denial of those conditions. Rex A. Howard, 42 Van Natta 2010 (1988). The order also reversed that portion of the Referee's order upholding SAIF's denial of other conditions, stating that "SAIF's denial of those conditions is set aside, and those portions of the claim are remanded to SAIF for processing according to law." Id. The Board's order was not appealed.

In February 1993, a Determination Order issued awarding additional temporary and permanent disability and providing an "aggravation date" of November 4, 1987.

Claimant filed a request for hearing asserting that the 1987 Determination Order was an invalid closure of his claim and, therefore, his aggravation rights did not begin with that document but, rather, with the February 1993 Determination Order. The Referee disagreed, concluding that, because the litigation before Referee Foster and the Board had no effect on the 1987 Determination Order, it closed the claim and, thus, claimant's aggravation rights expired five years after it issued.

On review, relying on Kociemba v. SAIF, 63 Or App 557 (1983), claimant argues that the 1987 Determination Order was "voided" by orders of Referee Foster and the Board finding that claimant had additional compensable conditions that were not medically stationary at the time of closure. We agree that, as a legal matter, claim closure is premature if any compensable condition is not medically stationary. E.g., Rogers v. Tri-Met, 75 Or App 470 (1985); Kociemba v. SAIF, supra. This is true even if the condition is consequential to the initial injury or disease. Id.

That holding, however, has been applied only in direct challenges to closure orders. In this case, claimant collaterally attacks the validity of the 1987 Determination Order and, therefore, may be subject to the principles of res judicata. Specifically, claimant may be precluded from challenging the 1987 Determination Order if finality has attached to the order.

Claimant did file a request for hearing from the 1987 Determination Order. However, in that request, he did not assert premature claim closure. On the contrary, during the hearing, claimant's attorney asked Referee Foster to determine extent of permanent disability, stating that all conditions, including those that were denied, were medically stationary. Furthermore, there was no discussion in Referee Foster's order or the Board's order regarding premature closure and the medically stationary status of any condition.[1] Instead, the orders considered only SAIF's denial and the compensability of the denied conditions.

Finality attaches to uncontested closure orders, barring future litigation of any issue determined by the order. See, e.g., Hammon Stage Line v. Stinson, 123 Or App 418, 423 (1993). We find that claimant did not contest the 1987 Determination Order during the prior proceedings before Referee Foster and the Board in that he did not challenge the "aggravation date" provided by the 1987 Determination Order, nor assert premature claim closure. Instead, claimant essentially sought to affirm the closure of his claim by asserting at hearing that all of his conditions were medically stationary and asking Referee Foster to rate permanent disability. Consequently, we conclude that the 1987 Determination Order is "final" for purposes of res judicata and claimant is barred from challenging it.

Furthermore, a claim for aggravation must be made within five years of the first claim closure even though the claimant sustains a subsequent compensable consequential condition. Mark D. Fuller, 46 Van Natta 63 (1994) (Board's own motion authority over a claim not affected by the existence of a consequential condition found compensable after the expiration of aggravation rights). Therefore, claimant's aggravation rights properly are determined based on the 1987 Determination Order. Inasmuch as five years have passed since the November 4, 1987 date provided by the order, claimant's aggravation rights have expired.

ORDER

The Referee's order dated May 26, 1993 is affirmed.

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[1] We find no effect on our conclusions by Referee Foster's statement in his order that "the claim was to be kept open by SAIF for treatment" of the compensable consequential conditions. The statement infers that Referee Foster considered the claim to be open, which in turn infers that Referee Foster also considered the Determination Order to have been overturned, which in turn infers that claimant asserted premature claim closure at hearing. However, we find that claimant's attorney's concession at hearing regarding the medically stationary status of all of claimant's conditions, and the complete absence of discussion in Referee Foster's order concerning premature closure, outweighs any inference that Referee Foster considered the claim to be in open status.

Board Member Hall dissenting.

I disagree with the majority's conclusion that claimant is precluded from challenging the November 4, 1987 Determination Order (D. O.) and that, therefore, his aggravation rights began as provided by the November 1987 order. Rather, I would find that the November 1987 order was rendered null and void by operation of law or, alternatively, set aside by operation of Referee Foster's January 1989 Opinion and Order and the September 1990 Board Order on Review. The current litigation is not a collateral attack on the 1987 DO since that DO did not legally exist after the Board's 1990 order finding additional non-medically stationary consequential conditions compensable. Therefore, I respectfully dissent.

The record shows that all of claimant's compensable consequential conditions were present and not medically stationary before the issuance of the 1987 Determination Order. Furthermore, as provided by the 1993 Determination Order, those conditions were not medically stationary until 1992. The 1987 Determination Order considered only claimant's initial accepted condition.

Under these circumstances, I would conclude that the 1987 Determination Order improperly closed the claim and was rendered void as a matter of law once the Board's September 1990 order, finding the additional non-medically stationary conditions compensable, became final. E.g., Kociemba v. SAIF, 63 Or App 557 (1983). The majority acknowledges this rule of law and recognizes the premature nature of a closing order under these facts. It is not clear, therefore, how an order which is rendered void ab initio can be collaterally attacked, as the majority suggests, when it no longer exists.

The November 1987 DO was at issue during the original proceeding before Referee Foster and the Board. Indeed, claimant sought permanent disability for all compensable conditions. Referee Foster's order implicitly recognized the void nature of the DO by properly declining to address permanent disability and ordering the claim to be "kept open" for processing of the additional (non-medically stationary) compensable conditions. For the same (implicit) reason, the Board also did not reach the issue of permanent disability and remanded the claim to SAIF for further processing. By operation of these orders, the November 1987 DO was set aside and, thus, again not subject to a "collateral" attack at this time.

Inasmuch as the 1987 Determination Order is void, it cannot constitute a final order precluding claimant from pursuing litigation. Thus, I would hold that claimant's aggravation rights began running upon issuance of the first valid (i.e., 1993) Determination Order and there has been no expiration of claimant's aggravation rights.

In the Matter of the Compensation of
WALTER D. HUTSELL, Claimant
WCB Case Nos. 92-04952 & 92-04953
ORDER ON REVIEW
Grantland, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Livesley's order which set aside its denial of claimant's right foot injury claim. On review, the issues are jurisdiction and coverage. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and offer the following summary of the relevant facts.

Liberty contracted with David Judd dba Pressure Point Roofing, Inc.(PPR), to provide workers' compensation coverage from September 13, 1990 through June 22, 1991. When PPR did not pay premiums, Liberty sent notice that it was cancelling coverage. The Compliance Section of the Department of Insurance and Finance gave Liberty notice that its liability for claims was terminated on July 21, 1991.

Meanwhile, in the spring of 1991, Barrett Business Services (BBS) approached Judd regarding an employee leasing agreement. Judd testified that he was given a copy of a proposed agreement dated May 19, 1991. The agreement provided that PPR's employees would be employed by BBS but leased back to PPR. BBS would provide workers' compensation insurance and carry PPR employees on its payroll.

Judd was considering the proposed contract, but had not yet decided to accept the offer, when claimant fell off a ladder on June 4, 1991, suffering a right foot injury. Concerned that his failure to pay the premiums on his Liberty policy might not result in coverage of claimant's injury, Judd testified that he signed the BBS leasing agreement, but back-dated his signature to June 3, 1991, the day before claimant's injury. BBS signed the agreement on June 8, 1991.

Judd forwarded claimant's injury claim to BBS on June 5, 1991. According to a payroll document dated June 25, 1991, claimant was placed on BBS's payroll effective June 1, 1991. (Ex. 19). BBS accepted claimant's injury on July 12, 1991. It processed the claim to closure on May 8, 1992.

In October 1991, Liberty audited Judd's payroll records. Judd informed Liberty that he had no employees effective June 1, 1991. (Ex. 40). However, counsel for Judd submitted a claim to Liberty on November 20, 1991, advising that claimant had been injured on June 4, 1991 and that the claim should have been forwarded to Liberty instead of BBS.

Liberty issued a denial on February 20, 1992 on the grounds that claimant was not an employee of PPR and that it did not provide coverage on June 4, 1991. Claimant did not appeal the denial, but Judd did. Subsequently, BBS issued a "back up" denial of the June 1991 injury on April 27, 1993. The BBS retroactive denial was not appealed and has become final.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Hearings Division had jurisdiction to consider Judd's appeal of Liberty's denial under ORS 656.283(1), which provides that any "party" may at any time request a hearing on "any question concerning a claim." Reasoning that Judd/PPR was claimant's employer on the date of injury, the Referee determined that Judd was a "party." See ORS 656.005(20). The Referee then found that, because Judd's appeal of Liberty's denial sought to change the status quo, there was a "question concerning a claim." See Glenn L. Woodraska, 41 Van Natta 1472 (1989).

After determining that the claim was compensable, the Referee then concluded that Liberty was responsible for the claim because claimant was an employee of Judd/PPR on the date of injury. The Referee specifically determined that Judd's testimony was credible regarding the back-dating of the leasing agreement with BBS and that the agreement was not effective prior to claimant's injury.

We agree with the Referee that Judd's appeal of Liberty's denial involves a "question concerning a claim." A "matter concerning a claim" is one in which a worker's right to receive compensation, or the amount therof, is directly at issue. ORS 656.704(3); Douglas Fredinberg, 45 Van Natta 1619, 1620 (1993). We find that a claimant's right to receive compensation is directly at issue when a denial of compensation is issued, regardless of whether or not claimant appeals. In other words, a determination that the Referee was without jurisdiction to consider Judd's appeal of Liberty's denial is the functional equivalent of a conclusion that claimant is not entitled to compensation for the June 4, 1991 injury insofar as it pertains to Judd/PPR. See Douglas Fredinberg, supra, 45 Van Natta at 1620. Moreover, since BBS's "back-up" denial had become final, a rejection of Judd's appeal of Liberty's denial would essentially preclude claimant from receiving further compensation under either claim.

Although BBS processed the June 4, 1991 claim to closure and the record does not indicate whether claimant is currently owed compensation, claimant would be effectively foreclosed from seeking any future compensation relating to the June 1991 injury if the Liberty denial also becomes final. Since we find that claimant's right to receive compensation is directly at issue, we conclude that Judd's appeal of the Liberty denial raises a "question concerning a claim."

We also agree with the Referee that Judd/PPR was a "party." ORS 656.005(20) defines a "party" as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." (Emphasis Supplied).

The Referee found Judd's testimony credible that he did not agree to the leasing contract until after claimant was injured and back-dated his signature to insure that claimant would receive worker's compensation benefits. The Referee's credibility determination, based in part on demeanor, is entitled to deference on review. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 284 (1987).

Given Judd's credible testimony, we do not find that the leasing agreement was effective prior to claimant's injury. Unlike the guaranty contract in Mary G. Mischke, 37 Van Natta 1155 (1985), mod D. Maintenance Co. v. Mischke, 84 Or App 218 (1987), no effective date is contained in the leasing agreement. (Ex. 2). In the absence of such a date, we decline to apply the leasing agreement retroactively to a date before claimant was injured. Instead, we find that the leasing agreement was effective no earlier than the date that Judd testified that he agreed to the contract, which was after claimant's injury.

In this regard, we note that BBS did not sign the agreement until June 8, 1991. (Ex. 2-17). Moreover, as the Referee noted, the leasing agreement provided that BBS would only agree to be the employer if personnel information was received. This information was not provided until June 12, 1991. (Ex. 13). Finally, the leasing agreement expressly provided that Judd and BBS would be "joint employers." (Ex. 2-3). These factors also lead us to conclude that Judd was claimant's employer at the time of injury and, therefore, a "party."

Our conclusion that an employment relationship existed between claimant and Judd is further reinforced by Judd's credible testimony that he was directing, controlling and supervising claimant's work at the time of injury. (Tr. 20, 47). Judd also testified that he was claimant's employer. (Tr. 47). Given this credible and undisputed testimony, we find that Judd was claimant's employer under the "right to control" test of Castle Homes v. Whaite, 95 Or App 269, 272 (1989), and Henn v. SAIF, 60 Or App 587, 591 (1982). See also Richard L. Morehouse, 45 Van Natta 1570, 1571 (1993).

Liberty contends, however, that BBS was claimant's employer on the date of injury because the leasing agreement was dated May 19, 1991, BBS accepted the claim, and Judd represented that he had no employees after June 1, 1991. Liberty also notes that BBS' payroll records show that claimant was on its payroll on June 1, 1991. We disagree with Liberty's contentions.

The fact that the leasing agreement was dated May 19, 1991 does not necessarily mean that was the effective date of the contract. Judd credibly testified that the leasing agreement was merely a proposal to which he had not agreed prior to claimant's injury. This fact, coupled with the lack of evidence in the agreement itself as to the effective date, leads us to conclude that there is insufficient evidence that the date of the proposed leasing agreement was the effective date. This conclusion is further supported by the unrebutted facts that neither Judd nor BBS executed the agreement until a date following claimant's injury and that the agreement was expressly contingent on BBS' receipt of personnel information which was not received until June 12, 1991.

In addition, our finding is not affected by BBS's acceptance of claimant's claim nor Judd's apparent representation that he had no employees after June 1, 1991. It appears that BBS accepted that claim without determining the validity of Judd's back-dated signature. Like the Referee, we also find it understandable that Judd would represent that he had no employees after June 1, 1991, given that he had back-dated the leasing agreement to insure that BBS would cover claimant's injury. Regarding claimant's appearance on Barrett's payroll in June 1991, the payroll document Liberty cites was dated June 25, 1991. Thus, there is no evidence in the record that BBS placed claimant on its payroll prior to his injury, although it may have retroactively done so.[1]

In conclusion, we agree with the Referee that the Hearings Division had jurisdiction to consider Judd's appeal of Liberty's denial. Judd was a "party" and there was a "question concerning a claim." See ORS 656.283(1). Moreover, inasmuch as Judd was claimant's employer at the time of injury and Liberty's coverage of Judd did not terminate prior to claimant's injury, Liberty is responsible for claimant's June 4, 1991 right foot injury.

ORDER

The Referee's order dated October 28, 1993 is affirmed.

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[1] Liberty cites an investigation undertaken by BBS (Ex. 18) as indicating that BBS had assumed Judd's payroll on or about June 3, 1991. However, the Referee did not admit this document into evidence.

In the Matter of the Compensation of
LORETA KING, Claimant
WCB Case No. 92-11763
ORDER ON REVIEW
Martin McKeown, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McWilliams' order which upheld the self-insured employer's denial of claimant's psychological claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a claims service assistant for an insurance company, filed an occupational disease claim for a mental disorder arising out of her relationship with her supervisor, the resident claims manager. The Referee determined that claimant suffered from a mental or emotional disorder generally recognized in the medical or psychological community and that she was subjected to stressors not generally inherent in every working situation. See ORS 656.802(3).

The Referee, nevertheless, concluded that claimant failed to sustain her burden of proving by clear and convincing evidence that employment conditions were the "major contributing cause" of her mental disorder. See Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987); Donna L. Armstrong, 45 Van Natta 1786, 1789 (1993). Specifically, the Referee found that a report from claimant's treating psychologist, Dr. Forester, did not establish major causation because Dr. Forester only stated that claimant's mental disorder was "materially" related to the workplace. (Ex. 16-10). While we agree that claimant did not sustain her burden of proving medical causation, our reasoning differs from that of the Referee.

Claimant contends the Referee placed too much emphasis on the word "material" in Dr. Forester's medical report and that we should consider the report in its entirety. We agree that the use of "magic words" is not a prerequisite for establishing medical causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). We also agree that the Referee's analysis too narrowly focused on Dr. Forester's use of the word "material." However, when Dr. Forester's medical report is examined as a whole, we still find it insufficient to satisfy claimant's burden of proving that it is highly probable that her employment is the major contributing cause of her diagnosed mental disorder. Donna L. Armstrong, supra.

Dr. Forester wrote that he was "unable to reveal any significant stressors in Mrs. King's life except her work." (Ex. 16-6). Dr. Forester noted no particular stressors related to claimant's marriage and recorded claimant's history of a normal childhood with no traumatic incidents. (Exs. 16-4, 5). Although apparently aware of claimant's previous psychological counseling in 1990, Dr. Forester considered this to have been the result of work related stressors only. (Ex. 16-6).

As the employer notes, Dr. Forester was unaware of, or gave short shrift to, numerous details of claimant's psychological history. For instance, claimant's father apparently subjected claimant to verbal abuse. (Ex. 5-4). This seriously undermines Dr. Forester's history of a normal childhood. In addition, claimant's marriage was subject to significant stressors. Claimant's husband was totally disabled as a result of work injuries. (Tr II, p. 8). This forced claimant to be the sole breadwinner, something that has been a source of resentment. (Ex. 5-5). Claimant's husband has also had other medical problems such as diabetes, severe asthma and emphysema. (Ex. 5-4). Most importantly, he was recently treated for cancer. Although the treatment was reportedly successful, it is apparent that this illness was a significant source of stress since it was a prominent stressor mentioned in Dr. Willey's May 7, 1992 chart note. (Ex. 12). Dr. Willey wrote that claimant was "stressed out" by her husband's medical problems. Moreover, when claimant sought counseling in 1990, she reported she had been "depressed for years." (Ex. 5-5). Claimant and her husband were also involved in litigation concerning an automobile accident in which her husband was injured. (Tr. II, pp. 35, 36).

In light of the above, Dr. Forester's history of no prior psychological problems and his belief that stressors in claimant's life in recent years had been low are not supported by the medical record. This in turn undermines the basis for his conclusion that there is even a "material" causal connection between claimant's psychological condition and her employment. Given its historical deficiencies, we cannot conclude that Dr. Forester's medical report establishes major causation, inasmuch as claimant must prove by clear and convincing evidence (i.e., that is highly probable) that her mental disorder arose out of her employment.

In conclusion, we agree with the Referee's finding that claimant did not satisfy her burden of proving medical causation, although for different reasons. Accordingly, we affirm the Referee's decision upholding the employer's denial. In light of our analysis, we need not, and do not, address the employer's alternative argument that the working conditions to which claimant was exposed are generally inherent in every working situation.

ORDER

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

In the Matter of the Compensation of
OSCAR M. MEDINA, Claimant
WCB Case No. 93-00293
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Hall.

The insurer requests review of Referee Baker's order that set aside its denial of claimant's low back condition. In its brief, the insurer also requests that we remand the case to the Referee for admission of additional evidence or consider such evidence on review. On review, the issues are res judicata, compensability, and remand. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

In 1983, claimant compensably injured his left knee and subsequently underwent numerous surgeries. In 1987, the insurer denied compensability of a "low back" condition. Claimant requested a hearing. In 1988, Referee Livesley allowed the insurer's motion to dismiss the matter based on a "lack of expert medical evidence as [to] causation[.]" In 1992, the insurer issued a denial of claimant's "current condition and treatment" including his "current back condition." The insurer challenges the Referee's conclusion that, because the current back condition was not the same as that denied in 1987, claimant was not prevented by res judicata from litigating the compensability of his current low back condition.

A September 1992 MRI showed that claimant had small disc herniations at L5-S1 on the left and L4-5 on the right. (Ex. 97-2). Dr. Fuller, orthopedic surgeon, and Dr. Peterson, neurologist, who examined claimant on behalf of the insurer, found that claimant's low back symptoms were caused by the L4-5 disc herniation. (Ex. 105-6). Furthermore, although noting that a 1987 CAT scan was "equivalent" to the 1992 MRI, the physicians determined that the difference in symptomatology between 1987 and 1992 indicated that claimant had a "new condition." (Id.)

Dr. James, orthopedic surgeon, treated claimant's left knee. He concurred with a letter written by the insurer's attorney stating that the "low back problem [claimant] had in 1986-87 and low back problem he had in 1982 [sic] were probable [sic] the same condition." (Ex. 112-1).

In a prior report, however, Dr. James stated that he had not examined or treated claimant's low back and, therefore, declined to comment on the cause of claimant's low back condition. (Ex. 105A). Based on these comments, we find Dr. James less qualified to address causation than Drs. Fuller and Peterson and, thus, consider his opinion less reliable. See Somers v. SAIF, 77 Or App 259 (1986).

Based on the report of Drs. Fuller and Peterson, we find that claimant's low back condition in 1992 was not the same as the low back condition in 1987. Therefore, compensability of claimant's current low back condition was not "actually litigated" in 1988 and, thus, issue preclusion is not applicable. See North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Furthermore, because claimant's current low back condition arose after the 1988 litigation, this proceeding does not concern the same factual transaction. Consequently, claim preclusion also does not apply. See Drews v. EBI Companies, 310 Or 134, 140 (1990).

Accordingly, we agree with the Referee that claimant is not precluded by the 1988 proceeding from litigating the compensability of his current low back condition.

Compensability

Claimant asserts that an altered gait that resulted from his left knee injury and ensuing surgeries caused his low back condition. Because claimant contends his low back condition was caused by his

compensable condition, rather than the industrial accident, claimant must show that his need for treatment with regard to the low back is in major part caused by his compensable left knee condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant relies on Dr. Kitchel, an orthopedic surgeon who treated claimant's low back. According to Dr. Kitchel, claimant's "altered gait" is the major contributing cause of his low back condition. (Exs. 108, 111). Dr. Kitchel based his opinion "purely" on claimant's history that he has limped since his 1983 injury. (Ex. 106).

We find persuasive reasons not to defer to Dr. Kitchel's opinion. First, there is no proof that claimant's gait has been permanently altered since 1983. Rather, the point was made by physicians during numerous examinations that claimant did not limp. (Exs. 27, 44, 76, 105-5). Thus, Dr. Kitchel did not base his opinion on an accurate history. Furthermore, Dr. Kitchel's opinion is not supported by that of Drs. Fuller and Peterson, who also found that, "apart from his immediate postoperative times, there is no evidence that a permanent limp has been present," and, thus, found that it was "just as likely that his current back condition stems from a vigorous basketball career as anything else." (Ex. 105-6). For these reasons, we do not defer to Dr. Kitchel as the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, Dr. James does not support compensability. For the same reasons discussed above, we find him less qualified to address causation. Moreover, although indicating that an altered gait could cause low back symptoms, he also agreed in the "check-the-box" report that he "could not say that knee problems are the major cause of claimant's current low back problems." (Ex. 112). Therefore, even if Dr. James was otherwise persuasive, his opinion does not carry claimant's burden of proof.

After reviewing the medical evidence, we find that, at best, it is in equipoise with regard to causation. Consequently, we conclude that claimant failed to prove by a preponderance of evidence that his compensable injury is the major contributing cause of his low back condition. See ORS 656.005(7)(a)(A).

Inasmuch as we have found that claimant did not prove compensability, we need not address the insurer's motion for remand to admit additional evidence.

ORDER

The Referee's order dated September 3, 1993 is affirmed in part and reversed in part. That portion setting aside the insurer's denial of claimant's low back condition claim is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

Board Member Hall, concurring in part and dissenting in part.

Although I agree with the majority that claimant is not precluded by res judicata from litigating the compensability of his current low back condition, I would find that claimant did prove compensability of the back condition.

According to Dr. Kitchel, claimant's treating physician for the back, an altered gait caused by claimant's compensable knee injury is the major contributing cause of his low back condition. I disagree with the majority that Dr. Kitchel relied upon an inaccurate history. I do not read Dr. Kitchel's opinion, as the majority apparently does, to be based on a history of claimant limping since 1983. Rather, Dr. Kitchel bases his opinion on claimant's "...limp and chronic knee surgeries with rehabilitation and altered gait since 1983..." (Ex. 108). I believe the majority too narrowly looks for evidence of a "limp" since 1983, when it is the broader impact of multiple surgeries, rehabilitation, and limping on altered gait which has caused claimant's back problem.

Claimant underwent seven compensable knee surgeries between 1983 and 1991, each with extended periods of recovery and rehabilitation, including one recovery period of a full year. (e.g., See Ex. 89). Indeed, as early as November 1987, Dr. James, claimant's treating doctor for the left knee, referred claimant to Dr. Kitchel for evaluation of claimant's low back (Ex. 49), and began recommending that claimant be retrained for sedentary employment (e.g., Exs. 50, 56, 59, 87-2). There can be little doubt, based on the evidence in this record, that claimant has suffered from a chronically unstable knee since 1983.

The opinion of examining physicians Fuller and Peterson is based on "...apart from his immediate postoperative times, there is no evidence that a permanent limp has been present." (Ex. 105, p. 6). Of course, when claimant's multiple "postoperative" periods are properly viewed one after the other, it is apparent claimant has suffered from a chronically altered gait as a result of his compensable, unstable knee. It is the opinion of Drs. Fuller and Peterson that is based on an inaccurate understanding of the medical history.

Based on such evidence, even in the absence of specific findings of a limp, I would find that claimant exhibited a chronically altered gait since his 1983 injury. Consequently, inasmuch as Dr. Kitchel relied upon an accurate history, I find no persuasive reasons for not deferring to his opinion. Based on that opinion, claimant proved compensability of his low back condition.

June 30, 1994 Cite as 46 Van Natta 1274 (1994)

In the Matter of the Compensation of
KAREN M. ANDERSON, Claimant
WCB Case No. 92-16011
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Bethlahmy's order that set aside its denial of claimant's cervical disc condition. On review, the issue is compensability.

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

The October 27, 1992 report by Dr. Gritzka was a medical arbiter's records review, rather than an independent medical examiner's records review.

The Referee found that claimant's herniated C5-6 disc is directly related to claimant's original injury. Therefore, applying the material contributing cause standard, the Referee concluded that claimant's disc condition is compensable as a "primary" consequence of the accepted May 1990 injury. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

On review, the employer renews its contention that because a "supervening event" occurred, claimant's herniated cervical disc should be analyzed as a "secondary" consequence of the compensable injury. Therefore, the employer argues that ORS 656.005(7)(a)(A) applies such that claimant has the burden to prove that the compensable injury was the major contributing cause of the neck condition for which she seeks medical treatment. We disagree.

Claimant sustained an injury to her left arm and upper back while performing her job duties on May 14, 1990. Two weeks later, on May 30, 1990, claimant's neck pain dramatically increased while she was standing up from bed. That same date, claimant sought treatment for her neck pain, and was diagnosed with a cervical strain. Thereafter, claimant filed a workers' compensation claim seeking compensation for the May 14, 1990 incident.

The employer accepted the claim on June 13, 1990. In August 1990, an MRI revealed a herniated disc at C5-6. Claimant continued to require ongoing medical care.

On January 12, 1993, the employer denied that claimant's current cervical disc condition and need for medical treatment are compensably related to her accepted shoulder and neck strain claim. A second MRI in February 1993 revealed that claimant's C5-6 disc had worsened and was impinging upon the dural sac.

The employer contends that the severe neck pain claimant experienced on May 30, 1990 was a "supervening event"/new injury. Although claimant reports that she felt severe neck pain at home

two weeks after she strained her arm and upper back at work, we are not persuaded on this record that claimant suffered a supervening event on that date. Claimant's testimony was that she was merely attempting to stand up from bed when the severe pain began. In addition, Dr. Puziss, claimant's treating physician, and Dr. Berkeley, consulting neurosurgeon, were aware that claimant's pain increased at home while attempting to stand up. Each of these physicians attribute claimant's neck pain to her work-related injury, rather than to standing up from bed.

Accordingly, we are not persuaded that claimant suffered a supervening injury to her neck at home. Therefore, as did the Referee, we find that claimant's herniated C5-6 disc is directly related to the original injury.

Alternately, relying on Ronald J. Lucier, 44 Van Natta 1268 (1992), the employer asserts that, even if there was not a superseding event, proof that the industrial injury is a material contributing cause of claimant's herniated disc is insufficient to establish a direct/"primary" causal relationship to the industrial injury. The employer misreads Lucier.

In Lucier, we first held that the claimant had not established that his current disc condition arose directly from his compensable injury. Rather, we found that the claimant's disc condition arose indirectly as a consequence of his compensable condition. Therefore, we explained, the claimant's disc condition would be found compensable only if his compensable injury was the major contributing cause of his consequential condition. See ORS 656.005(7)(a)(A). Analyzing the claimant's disc condition as a consequential condition claim, we found that the treating physician could only characterize the compensable injury as a "significant factor" in causing the claimant's condition.

In Lucier, we held that because the claimant had failed to prove that his current disc condition arose directly from his compensable injury, and because the medical reports limited the indirect causal impact of the compensable injury to a "significant factor," the claimant had failed to prove the requisite major causal relationship between the compensable injury and his consequential disc condition. Id. at 1268. Thus, Lucier did not change the requisite causal relationship for primary/direct consequences of industrial industries from the material contributing cause standard.

In the instant case, therefore, because we have found that claimant's herniated C5-6 disc is a direct/primary consequence of the May 14, 1990 injury, claimant need only prove that her work activities were a material contributing cause of disability or a need for medical treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, supra; Mark N. Wiedle, 43 Van Natta 855 (1991). Upon review of the medical evidence, we conclude that claimant has met her burden of proof.

Dr. Puziss opined that "it was reasonably medically probable that the material cause of the claimant's herniated C5 disc was her on the job injury of 5/14/90." Similarly, Dr. Berkeley opined that "it is within reasonable medical probability that the material cause of patient's C5-6 disc was the on-the-job injury that she sustained on May 14, 1990, and which became very severe on May 30, 1990." We decline, as did the Referee, to rely on the opinions of the medical examiners who concluded that claimant's C5-6 disc is secondary to the normal progression of degenerative disc disease, when there is no evidence in the record that claimant has degenerative disc disease.

Accordingly, we agree with the Referee that claimant has established the compensability of her herniated cervical disc condition.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,000, 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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 20, 1993 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
JOSE M. HERNANDEZ, Claimant
WCB Case Nos. 91-02166, 90-16765 & 90-18618
ORDER ON REVIEW
Rose, Senders, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Hoguet's order that: (1) set aside its denial of claimant's "new injury" claim for a bilateral upper extremity overuse syndrome condition; and (2) upheld the SAIF Corporation's denials of claimant's aggravation and "new injury" claims for the same condition. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and attorney fees for SAIF's allegedly unreasonable denials. On review, the issues are compensability, responsibility, penalties and attorney fees.

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

Claimant argues that SAIF "de facto" denied his claims for aggravation as represented by various medical reports sent to SAIF between April 1990 and August 1990. (See Exs. 72, 73, 75, 76, 77 & 78). Claimant contends that Dr. Puziss' medical reports described the worsening of his previously accepted "condition," (Ex. 40), and that SAIF had no legitimate doubt as to the compensability of claimant's aggravation claim. Therefore, claimant argues, he is entitled to penalties and attorney fees.

Inasmuch as claimant did not raise the "de facto" denial issue before the Referee, we are not inclined to address it on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). In any event, assuming that claimant had previously raised the "de facto" denial issue, we would still find no basis for awarding penalties or attorney fees against SAIF.

SAIF issued two denials: the first on August 22, 1990, denied an injury or occupational disease claim for bilateral wrist strain, (Ex. 79); and the second denial of February 7, 1991, denied a worsening of bilateral wrist tendinitis. (Ex. 91). SAIF argues that it was only denying a worsening of the specific carpal tunnel condition that it accepted by stipulation in 1987. (Ex. 67). The Referee found that the two prior stipulations entered into between claimant and SAIF (i.e. the all-encompassing stipulation of 1984 accepting claimant's "condition" and the specific stipulation of 1987 accepting claimant's bilateral carpal tunnel condition) created sufficient ambiguity to give SAIF legitimate doubt "as to the scope of what aspects of claimant's condition it was responsible for dating back to 1984." (O&O at 6).

Claimant contends that the Referee erred in holding that both of SAIF's denials were not compensability denials of conditions for which the Referee found Liberty responsible. (Resp. Br. at 7). However, claimant misinterprets the Referee's reasoning. The Referee never stated that the two denials were not compensability denials. Rather, the Referee found that SAIF accepted claimant's "overuse syndrome" when it accepted his bilateral carpal tunnel condition in 1984. SAIF consistently denied a worsening of that accepted condition; i.e., SAIF denied an aggravation claim for claimant's current condition.

Therefore, the Referee did not set aside the "compensability" portion of SAIF's two denials; rather, the Referee found that responsibility for claimant's overuse syndrome shifted to Liberty because claimant suffered a "new compensable injury." See ORS 656.308. Finally, the Referee merely reiterated a position that SAIF never disputed; i.e. SAIF remains responsible for claimant's accepted carpal tunnel syndrome.

A penalty may be assessed when a carrier "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 ambiguity between the 1984 and 1987 stipulations gave SAIF legitimate doubt regarding its liability for claimant's aggravation claim. Specifically, as discussed by the Referee, SAIF reasonably concluded that its liability was limited to the carpal tunnel acceptance of the second stipulation, not the subsequent diagnoses of overuse syndrome and/or radial nerve entrapment.

Finally, since SAIF did not concede the compensability of claimant's aggravation claim, and because Liberty was found responsible, claimant is not entitled to a carrier-paid attorney fee award payable by SAIF. However, claimant's attorney is entitled to an assessed fee for services on Board review, regarding the denial issues, payable by Liberty. 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 denial issues is $1,000, to be paid by Liberty. In reaching this conclusion, particular consideration has been afforded to the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for his unsuccessful efforts regarding the penalty and attorney fee issues.

ORDER

The Referee's order dated April 1, 1993, as amended April 15, 1993, is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Liberty Northwest Insurance Corporation.

June 30, 1994 Cite as 46 Van Natta 1277 (1994)

In the Matter of the Compensation of
ROGER D. JOBE, Claimant
WCB Case Nos. 92-15112 & 92-10152
ORDER OF ABATEMENT
Gary D. Taylor, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

The SAIF Corporation, on behalf of R. Keith Foster, a noncomplying employer, requests reconsideration of our May 6, 1994 Order on Review, as modified by our June 1, 1994 Order on Reconsideration. Specifically, SAIF requests reconsideration of that portion of our order which set aside its denial of claimant's current condition, with the exception of a C5-6 herniated disc.

SAIF relies upon our recent order in Bonni J. Mead, 46 Van Natta 755 on recon 46 Van Natta 1185 (1994). SAIF notes that Mead, supra, was issued subsequent to our order on reconsideration in the present case.

In order to allow sufficient time to consider the motion, we withdraw our May 6, 1994 order. Liberty Northwest Insurance Corporation and claimant are granted an opportunity to respond to SAIF's motion. To be considered, those responses must be submitted within 14 days from the date of this order. Furthermore, the parties should address the effect, if any, that Mead, supra, might have on this case. A copy of our order in Mead is enclosed. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
GORDON P. KIGHT, Claimant
WCB Case No. 91-09579
ORDER ON REMAND
Malagon, Moore, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Georgia-Pacific Corporation v. Kight, 126 Or App 244 (1994). The court has reversed our prior order that affirmed and adopted a referee's order that: (1) continued the hearing to allow claimant to depose his treating physician; and (2) set aside the self-insured employer's denial of claimant's occupational disease claim for his low back condition. Reasoning that the Board had abused its discretion in upholding the continuance without first making findings of extraordinary circumstances under OAR 438-06-091(4) and 438-06-081, the court has remanded for reconsideration. On reconsideration, we reverse.

FINDINGS OF FACT

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

On July 18, 1991, claimant requested a hearing regarding the employer's "de facto" denial of claimant's occupational disease claim for his current low back condition. Thereafter, the employer issued a written denial of the condition. (Ex. 24; see also Ex. 22). On July 31, 1991, claimant amended his request for hearing to respond to the employer's written denial.

On August 1, 1991, Dr. Bert, claimant's attending physician, issued his final written report in this matter. (Ex. 25).[1] On August 2, 1991, the Board issued a Notice of Hearing scheduling the hearing for October 17, 1991. The notice was amended on August 14, 1991 to notify the employer's attorney of the hearing date.

On September 20, 1991, claimant's counsel notified the employer's counsel by letter that he would need to depose Dr. Bert and that his office would be scheduling the deposition sometime "in the near future." (Ex. 27).

The hearing was held on October 17, 1991. At hearing, claimant requested a continuance to depose Dr. Bert. The employer objected to the continuance.[2] The Referee overruled the objection in his Opinion and Order. Dr. Bert was deposed on December 30, 1991. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

Remand to Referee/Continuance

By adopting the Referee's order, we relied on Dr. Bert's post-hearing deposition. In doing so, we found that claimant had shown due diligence in attempting to obtain Dr. Bert's testimony at hearing (who, according to claimant's counsel, was not available to attend the hearing and could not have been deposed for some six weeks). Accordingly, we concluded that claimant was entitled to a continuance.

Relying on OAR 438-06-091(4) and OAR 438-06-081(2) and (4), the court reversed and remanded. Georgia-Pacific Corporation v. Kight, supra. OAR 438-06-091(4) provides that a referee may continue a hearing for any reason that would justify a postponement of a scheduled hearing under 438-06-081. OAR 438-06-081 provides that "[a] scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." (Emphasis added). The rule expressly provides that "extraordinary circumstances" shall not include the following:

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[1] The record also contains an August 20, 1991 radiology report that was date stamped by claimant's counsel's office on October 7, 1991. Because claimant's counsel received the report after he announced his decision to depose Dr. Bert (see Ex. 27), it appears that the report had no bearing on counsel's decision to depose the doctor.

[2] At hearing, the employer initially conceded claimant's entitlement to a continuance. (Tr. 2-3). However, it later objected to the "manner" of the continuance (see Tr. 6-7, 48), and then "renewed" its objection to Dr. Bert's deposition in a post-hearing letter to the Referee and in its written closing argument.

"(2) Unavailability of a party, witness or representative due to * * * occupational, personal or professional business or appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person * * * is a person who has been duly subpoenaed and has failed to comply with the subpoena;

"* * * * *

"(4) Incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence." OAR 438-06-081(2), (4).

Since no "extraordinary circumstances" finding had been made, the court held that the Board had abused its discretion by upholding the continuance without first making the requisite findings. Kight, supra, 126 Or App at 248. Consequently, the court has remanded for reconsideration.

Before we reconsider the merits of whether claimant was entitled to seek a continuance, we address an argument claimant has raised for the first time on remand. In light of the court's disposition of this matter, claimant seeks remand to the Referee for further development of the record regarding the circumstances surrounding Dr. Bert's unavailability.

We may remand a case to a referee for further evidence taking if we find that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, the moving party must establish, inter alia, that the evidence clearly was not obtainable with due diligence at the time of hearing, and that the evidence is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988).[3]

Following our de novo review, we are not persuaded that the record has been insufficiently developed. On remand to the Referee, claimant seeks to present some unidentified evidence regarding the circumstances surrounding Dr. Bert's unavailability until his deposition in December 1991. Claimant has not explained how the unspecified evidence was not obtainable with due diligence at the time of hearing. On that ground alone, claimant's request for remand fails.

We are also not persuaded that the supplemental evidence is reasonably likely to affect the outcome of the case. Two rules are at issue here: OAR 438-06-081(2) and (4). As we stated earlier, as incorporated through OAR 438-06-091(4), OAR 438-06-081(2) provides that the unavailability of a witness due to occupational, personal or professional business or appointments, or unwillingness to appear shall not justify a continuance, unless the unavailable witness has been duly subpoenaed and has failed to comply with the subpoena. There is no evidence that Dr. Bert has failed to comply with a subpoena. Accordingly, we conclude that whatever evidence claimant planned to submit on remand to the Referee is not reasonably likely to affect the outcome of this case under OAR 438-06-081(2).

By incorporation through OAR 438-06-091(4), OAR 438-06-081(4) authorizes a continuance in a case of incomplete case preparation if the referee finds that completion of the record could not have been accomplished with due diligence. That rule focuses on the moving party's due diligence in completing case preparation before hearing. Evidence regarding the circumstances surrounding a witness' unavailability does not directly bear on the issue of a party's due diligence in completing case preparation. (The rules contemplate that witness unavailability would be addressed through the subpoena process). Accordingly, we conclude that evidence regarding the reasons for Dr. Bert's unavailability is not reasonably likely to affect the outcome of this case under OAR 438-06-081(4), particularly when Dr. Bert was not subpoenaed, the record already establishes when claimant requested

[3] In his reply brief, claimant argues that Tallent and Compton are inapposite, because they involved requests for remand for admission of medical records not yet in evidence, whereas this case involves some unidentified evidence regarding Dr. Bert's unavailability that the parties evidently discussed off the record. Claimant's argument is based on a distinction without a difference.

a hearing, when he was notified of the hearing date, when Dr. Bert issued his final pre-hearing report, and when claimant first notified the employer of the need to depose Dr. Bert.[4]

For these reasons, we conclude that the record is sufficiently developed for our review, and we deny claimant's request to remand this case to the Referee. We now turn to the merits of this issue.

Based on claimant's arguments on remand, it appears that claimant believes that he was entitled to a continuance to take Dr. Bert's deposition pursuant to either OAR 438-06-081(2) or (4). We disagree.

As we have discussed earlier, to constitute "extraordinary circumstances" warranting a continuance under OAR 438-06-081(2), claimant must show that Dr. Bert was unavailable because he failed to comply with a subpoena. There is no evidence to that effect. Accordingly, OAR 438-06-081(2) is of no help to claimant.

That leaves OAR 438-06-081(4). Under that rule, claimant may be entitled to a continuance for incomplete case preparation only if he demonstrates that completion of the record could not have been accomplished with due diligence. On this record, we conclude that claimant has not met that burden.

The evidence reveals that, at the latest, claimant's counsel decided on September 20, 1991 that he would depose Dr. Bert. (See Ex. 27). That decision was made more than six weeks after Bert had issued his final written report in this matter (see Ex. 25), and nearly four weeks prior to hearing. Claimant's counsel next raised the deposition issue at hearing, when he requested a continuance to depose Dr. Bert. (Tr. 2). At the time, claimant's counsel's office had yet to confirm the arrangements for the deposition. (See id.)

The record is silent as to why claimant's counsel waited more than six weeks after the issuance of Dr. Bert's final written report before advising the employer's counsel of his intent to depose Bert. More importantly, the record is devoid of any evidence regarding what, if anything, claimant's counsel did between September 20 and October 17 to attempt to obtain Dr. Bert's testimony. In closing argument, claimant's counsel asserted that Dr. Bert required six-weeks' notice for depositions and that Bert's live testimony at hearing would have been prohibitively expensive. However, there is no evidence in the record to support those representations. See Cruz v. SAIF, 120 Or App 65 (1993) (attorney's unsupported representations are not evidence). Moreover, even if there were such evidence, it would not establish when (or if) claimant's counsel attempted to make arrangements to obtain Dr. Bert's deposition. On this record, we conclude that claimant has not met the due diligence standard of OAR 438-06-081(4). Accordingly, claimant was not entitled to a continuance under that rule.

In sum, we conclude that claimant has failed to establish his entitlement to a continuance to depose Dr. Bert. Therefore, we do not consider Dr. Bert's deposition in evaluating the compensability of claimant's current low back condition.

Compensability

Claimant has asserted that his current low back condition is a new occupational disease. His theory, which is based on Kepford v. Weyerhaeuser Company, 77 Or App 363 (1986), is that his 1981 compensable low back injury, and ensuing surgery, in combination with his subsequent work activities, were the major contributing cause of his current low back condition. In the absence of Dr. Bert's deposition, we conclude that claimant has failed to prove his case under that theory.

The medical evidence consists of the written reports of Drs. Bert and Whitney, claimant's treating physicians, and Dr. Thompson, examining physician. Dr. Whitney concluded that claimant's current low back condition was related to claimant's surgery. (Ex. 1-7). Dr. Thompson concluded that

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[4] We do not know what claimant planned to submit as additional evidence on remand to the Referee. Given that we have concluded that OAR 438-06-081(4) contemplates proof of the moving party's efforts to secure a witness' testimony, we envision that a claimant could establish due diligence through, for example, telephone records or other correspondence regarding those efforts. Claimant has apprised us of no such evidence. Moreover, even if such evidence were produced, we would question why it was not available at the time of hearing. See Compton v. Weyerhaeuser Co., supra; Metro Machinery Rigging v. Tallent, supra.

the condition was probably related in part to the 1981 injury, and in part to a congenital anomaly. (Exs. 18, 20). In his final written report in August 1991, Dr. Bert concluded that claimant's current need for treatment was related to his 1981 injury. (Ex. 25). However, Bert also stated that it was "more likely than not that [claimant's] work activities were the major contributing cause of his present back problems." (Id.)

We conclude that this evidence fails to establish the compensability of claimant's current low back condition as a new occupational disease. The only report that even remotely supports claimant's theory is Dr. Bert's. We discount that opinion because it is conclusory and it appears to be internally inconsistent. See Somers v. SAIF, 77 Or App 259 (1986). For these reasons, we conclude that claimant's occupational disease claim fails.

Accordingly, on reconsideration, the Referee's order dated July 2, 1992 is reversed. The self-insured employer's denial of claimant's occupational disease claim for his current low back condition is reinstated and upheld. The Referee's attorney fee award is reversed.

IT IS SO ORDERED.

June 30, 1994 Cite as 46 Van Natta 1281 (1994)

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 93-06873
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

The SAIF Corporation requests review of Referee Galton's order that: (1) set aside its denial of claimant's blood clot condition in his left leg; and (2) awarded an attorney fee under ORS 656.382(1) for an allegedly unreasonable denial. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the findings of fact contained in the Referee's order, except that we do not adopt the Referee's "Ultimate Findings of Fact." We supplement the Referee's findings as follows.

For purposes of background information concerning claimant's prior claims, we incorporate by this reference our previous order, James M. King, 45 Van Natta 2354 (1993) (a decision which issued subsequent to the Referee's order).

On February 23, 1993, claimant had surgery for a blood clot in his left leg. SAIF denied the claim on the ground that claimant's 1977 myocardial infarction was not the major contributing cause of his condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAIF was precluded from relitigating the compensability of claimant's coronary artery disease (CAD) by virtue of prior litigations. Alternatively, based on the opinion of claimant's treating cardiologist (Dr. Semler), as supported by claimant's recent surgeon (Dr. Donnelly), the Referee determined that claimant's compensable CAD was the major contributing cause of his current left leg blood clot condition. Consequently, the Referee set aside SAIF's denial. We disagree and reverse.

As a threshold matter, claimant argues that SAIF is taking a new position than it took at hearing. Specifically, rather than basing its denial on a theory that claimant's blood clot is related to a noncompensable CAD, claimant asserts that SAIF has improperly supplemented its position so as to deny an artery disease in claimant's left iliac and femoral artery. We need not address this argument because, based on SAIF's "hearing/CAD" theory, we conclude that the blood clot condition is not compensable.

When a condition or need for treatment is caused by a compensable injury, a claimant must prove that the compensable injury was the major contributing cause of the current condition. ORS 656.005(7)(a)(A). We are not persuaded that claimant has satisfied his requisite burden of proof for the following reasons.

Four physicians provided opinions regarding the cause of the February 1993 blood clot in claimant's femoral artery. The physicians disagree as to whether claimant's blood clot originated in the left ventricle of his heart or in his femoral artery.

When there is a dispute between medical experts, we rely on those opinions that are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259, 263 (1986). Claimant argues that we should give greater weight to the opinions of Dr. Semler and Dr. Donnelly because they were the treating physicians. See Weiland v. SAIF, 64 Or App 810 (1983). However, we find that this case involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference in this case. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979).

Dr. Semler, a cardiologist, concluded that claimant's blood clot originated in the left ventricle of the heart and traveled to the left femoral artery. Dr. Semler reported:

> "[Claimant's] compensable condition, as I understand it, is coronary artery disease and the most likely tie-in for his recent episode of blood clot in the left femoral artery turns out to be an 'embolus' or blood clot having come from the heart.
>
> "There is evidence from his echocardiograms that he had a blood clot in the apex of the left ventricle. This would indicate this is a source where the blood clot traveled to the left femoral artery in his thigh and led to his needed surgery by Doctor William Donnelly at East Moreland Hospital.
>
> "The clot arising in the heart is most likely related to his coronary artery disease. The blood clot was there as a result of his previous heart attack which was the result of the coronary artery disease which has been determined to be compensable." (Ex. 26).

Dr. Semler's opinion is based on his understanding that claimant's CAD was a compensable condition. After the Referee issued the order in this case, we decided that claimant's CAD was not compensable. James M. King, supra. We conclude that Dr. Semler's opinion is not persuasive because it is based on his understanding that claimant's CAD was compensable, an opinion which is against the law of the case. See Kuhn v. SAIF, 73 Or App 768 (1985); James V. Compton, 45 Van Natta 1442 (1993).

Claimant argues that Dr. Donnelly's opinion is entitled to great weight because he performed the femoral artery surgery in February 1993. In a "check-the-box" opinion, Dr. Donnelly concurred with Dr. Semler's reports. (Ex. 27). Because Dr. Donnelly's opinion suffers from the same deficiencies as Dr. Semler's opinion, we do not find it persuasive. See Somers v. SAIF, supra.

On the other hand, Dr. Toren, a cardiologist, believed it was more likely that claimant's thrombus formed at the site of the femoral artery rather than traveling from the left ventricle. (Ex. 23). Dr. Toren's opinion was based on two factors. First, claimant's blood clot occurred at the site of severe occlusive arteriosclerotic disease. Dr. Toren noted that claimant's vascular disease was severe enough that it was necessary to do reconstructive surgery. Second, Dr. Toren explained that the type of left ventricular thrombus described by Dr. Semler (a mural thrombus) has been found to be at the lowest risk of embolization. Dr. Toren described a mural thrombus as "an organized clot, more or less plastered against the wall of the left ventricle." (Id). Claimant's thrombus had not been described as demonstrating motion. Dr. Toren concluded that it was medically probable that claimant's blood clot "was due to the consequences of arteriosclerotic peripheral vascular disease, unrelated to his prior myocardial infarctions and bypass surgery." (Id).

Dr. Porter, professor of vascular surgery at the Oregon Health Sciences University, reviewed claimant's medical records and reported:

> "The chart indicates clearly that the cause of [claimant's] acute symptoms on the day of the surgery regarding his left leg was the formation of a thrombus in his left profunda femoris artery which was, without question, an in-situ thrombosis. In my opinion, there is no reasonable "probability, whatsoever, that a left ventricular derived embolus caused the symptoms requiring surgical treatment on 2/23/93." (Ex. 25).

Dr. Porter concluded that claimant's blood clot in his left leg was not causally related to his myocardial infarction. (Id).

After reviewing the medical opinions, we find the opinions of Drs. Toren and Porter to be more persuasive because they are better reasoned and are based on an accurate history, consistent with the "law of the case." See Somers v. SAIF, supra. Consequently, we conclude that claimant has failed to prove that the 1977 myocardial infarction and coronary bypass surgery and the 1988 myocardial infarction were the major contributing cause of his surgery and treatment for a blood clot in the left femoral artery in February 1993. See ORS 656.005(7)(a)(A). Accordingly, SAIF's denial is reinstated and upheld.

In light of this conclusion, it follows that SAIF had a legitimate doubt as to its liability for the claim. Consequently, we do not find its denial unreasonable. Therefore, we reverse the Referee's attorney fee award for an unreasonable denial.

ORDER

The Referee's order dated October 6, 1993 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee awards are also reversed.

Board Member Gunn dissenting.

For the reasons set forth in my dissenting opinion in the prior order, James M. King, 45 Van Natta 2354 (1993), I adhere to my position that SAIF is barred from denying claimant's coronary artery disease condition. Therefore, I would affirm the Referee's order setting aside SAIF's denial of June 3, 1993.

The medical opinions clearly establish that claimant's coronary artery disease (CAD) caused the blood clot condition in his left leg. Dr. Semler, claimant's treating physician, reported that the blood clot in claimant's leg was there "as a result of his previous heart attack which was the result of the coronary artery disease which has been determined to be compensable." (Ex. 26). Dr. Donnelly concurred with Dr. Semler's opinion. (Ex. 27). Dr. Porter agreed that claimant's blood clot in his leg was causally related to the underlying generalized disease of atherosclerosis. (Ex. 25).

Accordingly, based on the foregoing reasoning, I respectfully dissent from the majority's decision to uphold SAIF's denial.

In the Matter of the Compensation of
ROBERT M. MITCHELL, Claimant
WCB Case No. 93-06133
ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our June 6, 1994 Order on Review that awarded a $1,500 carrier-paid attorney fee under ORS 656.382(2) for claimant's counsel's efforts on review regarding the successful defense of that portion of the Referee's order which set aside the SAIF Corporation's denial of claimant's current low back condition. Asserting that SAIF did not object to his counsel's statement of services, claimant contends that the attorney fee award should be increased to $3,240 (the amount requested in the statement of services).

In response, SAIF argues that claimant's counsel's statement of services should not be considered because it was not filed with claimant's respondent's brief. See OAR 438-15-029(2)(a). Moreover, reasoning that $1,500 is a reasonable attorney fee award, SAIF contends that the award should not be increased.

A request for an assessed attorney fee on Board review shall be considered if the request is included with a timely filed appellate brief. See OAR 438-15-029(2)(a). Here, claimant's respondent's brief was filed on January 7, 1994. The brief was not accompanied by claimant's counsel's statement of services. Rather, counsel's statement was filed on January 17, 1994, some 5 days after SAIF filed its reply brief.

Inasmuch as claimant's counsel's statement of services was untimely filed, it will not be considered. Nevertheless, since claimant has timely sought reconsideration of a Board order and a portion of that decision pertained to claimant's attorney fee award under ORS 656.382(2), we will reconsider our attorney fee award. In doing so, we will neither consider claimant's references to specific information contained in claimant's counsel's untimely filed statement of services nor specific objections to any of those representations which were made in that statement. See Anthony Foster, 45 Van Natta 1997 (1993). Instead, we will base our determination of a reasonable attorney fee award on a reexamination of the record and the appellate briefs. Id.

This case arose from SAIF's appeal of a Referee's order which set aside SAIF's denial of claimant's current low back condition as allegedly unrelated to his 1983 compensable injury. SAIF also sought review of that portion of the Referee's order which assessed a penalty for SAIF's allegedly unreasonable claim processing.

The record consists of approximately 90 exhibits and a 26-page transcript (claimant was the only witness). On Board review, SAIF submitted an 8-page appellant's brief which was primarily devoted to the proposition that claimant's current condition constituted a "resultant condition" under ORS 656.005(7)(a)(B) and was due to a prior low back injury/surgery, rather than to the 1983 compensable injury. In response, claimant submitted a 12-page respondent's brief, contending that, since claimant's current condition was not a "resultant condition," the "major contributing cause" standard of section (7)(a)(B) was not applicable. Based on a material contributing cause standard, claimant asserted that he had established the compensability of his current condition. Finally, claimant briefly supported the Referee's penalty assessment. In a 4-page reply, SAIF again asserted that claimant's condition was not compensable because the 1983 injury was not the major contributing cause and that the Referee's penalty award should be reversed.

We affirmed the Referee's compensability decision, agreeing with claimant that a "material contributing cause" standard was appropriate. Turning to the penalty issue, we found that SAIF's conduct had been unreasonable. Nevertheless, since there were no amounts then due on which to base a penalty, we eliminated the Referee's penalty assessment and replaced it with a $500 attorney fee under ORS 656.382(1) for SAIF's unreasonable resistance to the payment of compensation.

After reconsidering this case in light of the factors set forth in OAR 438-15-010(4), we draw the following conclusions. Although claimant's aggravation rights have expired, this compensability issue and the benefit secured are of value because this decision affirms claimant's entitlement to receive medical services for his low back condition/surgery. In addition, this compensability finding has

The Stone II court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that OAR 436-60-030(2) was inconsistent with ORS 656.212, in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the Stone II court reasoned that an injured worker's 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. Specifically, the Stone II court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Relying on Stone II, the court has reversed our prior order and remanded for reconsideration. Studer v. N.W. Agricultural Co-op, supra. In accordance with the court's mandate, we proceed with our reconsideration.

Here, other than evidence confirming that claimant's at-injury wage was not affected by his return to modified work, there is essentially no documentary or testimonial evidence in the record regarding claimant's "earning power at any kind of work." In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work.

Because this record was developed prior to the Stone II court's interpretation of ORS 656.212 and its attention to diminished earning power at any kind of work in calculating TPD, the parties did not have an opportunity to present evidence or argument on this crucial issue. Therefore, we find that there is a compelling reason to remand for the submission of additional evidence solely concerning claimant's loss of earning power at any kind of work. See ORS 656.295(5); Lori A. Auterson, 46 Van Natta 262 (1994); Troy Shoopman, 46 Van Natta 21 (1994). At this "remand" proceeding, the parties are also requested to address the effect, if any, the Director's temporary amendments to OAR 436-60-003 and 436-60-030 have on this issue.[1] See WCD Admin Order 94-050.

Accordingly, we vacate the Referee's order dated April 2, 1992, as reconsidered April 24, 1992. This matter is remanded to Referee Brazeau for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice, although we would recommend that evidence concerning claimant's employment history (including past/current wages) be presented. See Shoopman, supra at 22 n.2; see also WCD Admin. Order 94-050. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] We realize that the Board requested supplemental briefing from the parties regarding the effect, if any, these temporary rules have on this case. However, inasmuch as this case is being remanded to the Hearings Division for further proceedings regarding claimant's loss of earning power at any kind of work, the parties may address their arguments to the Referee regarding the applicability, effect and/or legality of these temporary rules.

In the Matter of the Compensation of
HENRY L. STUDER, Claimant
WCB Case No. 91-18057
ORDER ON REMAND (REMANDING)
Malagon, Moore, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Studer v. N.W. Agricultural Co-op, 126 Or App 739 (1994). The court reversed our prior order in Henry L. Studer, 45 Van Natta 214 (1993), which held that claimant was not entitled to temporary partial disability (TPD) benefits because he was terminated for reasons unrelated to his compensable injury and, at the time of his termination, his wages equaled or exceeded his at-injury wages. Specifically, we have been directed to reconsider our decision in light of Stone v. Whittier Wood Products, 124 Or App 117 (1993), rev den 318 Or 459 (1994), hereinafter Stone II.

FINDINGS OF FACT

We adopt the findings of fact contained in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his neck and thoracic spine in March 1985 while employed as a truck driver. In December 1989, claimant left work because of an inability to continue truck driving. Subsequently, he began receiving vocational assistance and, on September 9, 1991, claimant began working as a truck dispatcher in a wage subsidy program. Claimant was paid $2,500 per month, which was equal to or greater than the wage he earned at the time of his injury. On November 20, 1991, claimant was terminated for reasons unrelated to his compensable injury. Specifically, claimant was terminated for his alleged personal use of the employer's toll-free telephone number, conduct that was prohibited by the employer. The SAIF Corporation did not reinstate temporary disability benefits after claimant's discharge.

Claimant requested a hearing, raising the issue of TPD, among other issues. By order issued on April 2, 1992, as reconsidered on April 24, 1992, Referee Brazeau concluded that claimant was entitled to temporary disability compensation following his termination. The Referee reasoned that claimant's termination was not due to a violation of normal employment standards. Therefore, the Referee concluded that the job offer had been "withdrawn" pursuant to OAR 436-60-030(4)(b) and that claimant was entitled to temporary disability compensation.

SAIF requested Board review of Referee Brazeau's order. Relying on the court's earlier decision in Stone v. Whittier Wood Products, 116 Or App 427 (1992), hereinafter Stone I, the Board concluded that it was not required to determine whether claimant's discharge was unlawful before it could determine his entitlement to temporary disability benefits, so long as the discharge was not related to claimant's compensable injury. Henry L. Studer, supra. The Board also relied on the court's decision in Stone I and its decision in Safeway Stores v. Owsley, 91 Or App 475 (1988), in concluding that, because claimant had been terminated for reasons unrelated to his compensable injury and he was earning wages that equaled or exceeded his at-injury wages for the modified work he was performing at the time of his termination, he was not entitled to temporary disability benefits after his discharge. On that basis, the Board reversed the Referee's decision regarding the temporary disability issue.

Subsequent to the Board's order, the court reconsidered its Stone I decision. Although the court continued to hold that the Board was not required to determine whether a worker's discharge was unlawful before it could determine his or her entitlement to temporary disability benefits, it reevaluated the test used to determine a worker's entitlement to temporary disability benefits after termination (for reasons unrelated to the compensable injury) from modified employment that paid the worker's regular wage.

In Stone II, the court reversed a Board order which had found that the claimant was not entitled to temporary disability because she had been discharged from her modified job for reasons unrelated to her compensable injury (violation of a drug/alcohol policy). Computing the claimant's TPD under OAR 436-60-030(2) at zero, the carrier in Stone II did not reinstate temporary disability benefits after her discharge.

claimant's claim) for the penalty and the penalty-related attorney fee are the same. See Nicolasa Martinez, 43 Van Natta 1638, 1640 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Rather, in lieu of an attorney fee, claimant's counsel is entitled to one-half of the penalty. ORS 656.262(10). The Referee's order will be modified accordingly.

Penalties For Discovery Violation

The Referee found that the insurer had not timely provided discovery pursuant to the Board rules (OAR 438-07-015(2)) and assessed a 5 percent penalty. We disagree.

When a discovery violation is alleged which occurs prior to a request for hearing being filed, the Board rules concerning discovery are not applicable. See Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991). Rather, the Director's rules are applicable. Id. The Director's rules require unarchived files to be provided within 15 days of receipt of a request. OAR 436-60-015(4).

Here, claimant alleges that the insurer unreasonably failed to provide discovery in response to his counsel's October 8, 1992 request. Claimant's request for hearing was not filed until January 11, 1993. Thus, the Director's rules, rather than the Board's rules concerning discovery are applicable. Boehr, supra. Although claimant alleges that he was provided discovery untimely, he has submitted no evidence with regard to when his discovery request was complied with. Consequently, on this record, claimant has not established that the insurer's actions were unreasonable. Therefore, we do not find that a penalty is warranted in this circumstance.

Attorney Fees

We adopt the Referee's conclusions and reasoning concerning the attorney fee issue as set forth in the Referee's order with the following supplementation.

The insurer contends that the Referee's award of a $1,000 assessed attorney fee for claimant's counsel's services in obtaining claim acceptance is excessive. 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 attorney fee for obtaining the acceptance of claimant's claim by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

Offset

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

Finally, we note that claimant is not entitled to an attorney fee on review for defending the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 14, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which awarded a 5 percent penalty for the insurer's allegedly unreasonable discovery violation is reversed. That portion of the Referee's order which awarded a $1,000 penalty-related attorney fee for the insurer's unreasonable claims processing is reversed. The 20 percent penalty awarded by the Referee, based on the amounts due claimant at the time of claim acceptance, is to be paid to claimant and claimant's counsel in equal shares. The remainder of the order is affirmed.

the non-hearing alternative, there is nothing in the record to indicate that the Referee rescheduled the hearing as he said he would in his September 23, 1992 letter. Consequently, there is no basis for Referee Quillinan's finding that claimant has failed to explain why he had not complied with Referee McCullough's request and that claimant's lack of cooperation had occasioned a delay in the hearing of more than 60 days. See OAR 438-06-071(1). Therefore, we vacate the Referee's dismissal order and reinstate claimant's hearing request.

ORDER

The Referee's order dated December 30, 1992 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to the Referee McCullough with instructions to schedule claimant's case for hearing in accordance with the Board's rules.

June 30, 1994 Cite as 46 Van Natta 1299 (1994)

In the Matter of the Compensation of
TRENTON STEWART, Claimant
WCB Case No. 93-00456
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Referee Peterson's order that: (1) assessed a penalty for allegedly unreasonable claims processing; (2) assessed a penalty for an allegedly unreasonable discovery violation; and (3) awarded claimant's counsel an assessed attorney fee for prevailing over its "de facto" denial of claimant's right knee injury claim. Claimant cross-requests review of that portion of the Referee's order that allowed the employer to offset out-of-state unemployment benefits against temporary disability benefits. On review, the issues are penalties, attorney fees, and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Penalties For Unreasonable Claims Processing

The Referee found that the insurer's claims processing was unreasonable and assessed a penalty equal to 20 percent of the amounts due at the time of the insurer's acceptance. In addition, the Referee awarded claimant's counsel a $1,000 penalty-related attorney fee. We agree with and adopt the Referee's reasoning and conclusion that the insurer's claims processing was unreasonable. However, we modify that portion which awarded claimant's counsel an assessed attorney fee.

As a preliminary matter, the insurer asks that the Referee's order be clarified with regard to what amounts the penalty is based on. As the Referee's order noted, the penalty is based on all amounts due as of the time of claim acceptance. We believe the order is self-explanatory. However, in the interest of clarification, claimant is awarded a penalty equal to 20 percent of all amounts due claimant as of January 11, 1993, the date the insurer accepted the claim. See Jeffrey D. Dennis, 43 Van Natta 857 (1991).

The Referee also awarded a penalty-related assessed attorney fee for the insurer's unreasonable claims processing. We disagree.

Inasmuch as claimant is entitled to a penalty under ORS 656.262(10), claimant is not entitled to the assessment of an attorney fee under ORS 656.382(1) as the factual basis (failure to timely accept

On September 23, 1992, Referee McCullough wrote to claimant and SAIF, proposing that the parties either reschedule the case for another hearing date or proceed based on written submissions. Referee McCullough proposed a multi-step procedure regarding submission of evidentiary materials. The Referee indicated that SAIF had agreed to the non-hearing alternative and he asked claimant to advise whether that alternative was acceptable. Referee McCullough stated that if the alternative was acceptable, he would "await compliance with the above-outlined steps." If it was not acceptable, he would reschedule the hearing.

On September 28, 1992, claimant responded to Referee McCullough. Claimant stated, in part: "I will not consider the alternative multi-step procedure without SAIF withdrawing all exhibits (including those not on the master exhibit list) except numbers one through eleven and fourteen through eighteen, and [claimant's former attorney] withdrawing all of his claims." Claimant also requested permission to review his file and another claimant's file.

On October 13, 1992, Referee McCullough wrote to claimant, explaining that claimant's file and the file of another claimant had been sent to Eugene for his review. Referee McCullough made no mention of claimant's response to the Referee's previous non-hearing alternative.

On December 1, 1992, Referee Quillinan wrote to claimant regarding Referee McCullough's September 23, 1992 letter. Referee Quillinan said that the "file does not reflect that you have either objected to the procedure outlined in the September 23, 1992 letter or complied with it." Referee Quillinan advised that the matter would be reset for hearing and that the case would not be reset again for any reason. On December 2, 1992, claimant responded to Referee Quillinan that he did not recall Referee McCullough's September 23, 1992 letter and did not understand what she was talking about.

On December 14, 1992, Referee Quillinan sent claimant a copy of Referee McCullough's September 23, 1992 letter and asked him to submit the information requested in that letter within 10 days. Referee Quillinan advised that the failure to do so would result in the dismissal of his case in light of the fact that he had had since September 23, 1992 to comply. Claimant responded on December 23, 1992, stating "I could not find enclosed a notice that SAIF withdrew items under which conditions I previously agreed. Please submit an affidavit."

On December 30, 1992, Referee Quillinan dismissed claimant's case with prejudice. Referee Quillinan found that claimant had not responded to Referee McCullough's September 23, 1992 request for claimant to provide exhibits and other affidavits necessary to complete the evidentiary record. Referee Quillinan also found that claimant had failed to explain why he could not comply and that claimant's lack of cooperation had occasioned a delay in the hearing of more than 60 days. See OAR 438-06-071. In our previous order, we adopted and affirmed the order of the Referee. Nick Shevchynski, supra.

CONCLUSIONS OF LAW AND OPINION

The Referee is authorized to dismiss a proceeding under OAR 438-06-071(1) only if "the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days." Here, there is no evidence that claimant has abandoned his request for hearing. Moreover, claimant's conduct has not caused an unjustified delay in the hearing.

There is no evidence to support the Referee's finding that claimant had not responded to Referee McCullough's September 23, 1992 request for claimant to provide exhibits and other affidavits necessary to complete the evidentiary record. Claimant did respond to Referee McCullough's request in his letter of September 28, 1992. Claimant indicated that he would accept the non-hearing alternative if SAIF would comply with his request regarding the withdrawal of certain exhibits and if claimant's former attorney would withdraw his claims. In December 1992, when Referee Quillinan asked claimant to submit the necessary information, claimant indicated that he had not yet received notice that SAIF had complied with his request to withdraw the exhibits.

There is nothing in the record to indicate whether claimant's conditions were accepted or rejected. Even if we assume that Referee McCullough interpreted claimant's response as a rejection of

findings of an impingement syndrome, and in which he made another request to perform an acromioplasty surgical procedure; and (2) Dr. Thomas' May 12, 1992 operative report of the arthroscopy of the right shoulder and subacromial debridement in which he found scarring of the bursa in the subacromial region for which he performed a bursectomy, removed part of the acromion and incised the coracoacromial ligament.

Moreover, we find that these reports constitute prima facie evidence, supported by objective findings, that claimant's condition had worsened since the previous award of permanent disability and that the worsening was more than a waxing and waning of symptoms contemplated by the previous award. See Stanley Smith Security v. Pace, supra, at 609. Accordingly, the insurer was statutorily required to begin the payment of interim compensation no later than June 11, 1992, the 14th day after May 28, 1992, until termination of those benefits is authorized by statute. See ORS 656.273(6).

Inasmuch as this claim has been found compensable, claimant is entitled to interim compensation in the form of temporary disability commencing from the date of claimant's disability. See Sandra L. Berkey, 41 Van Natta 944, 945 (1989). Since the record supports a conclusion that claimant was disabled as of May 12, 1992 and because that is the date that she seeks the commencement of temporary disability benefits, we find that May 12, 1992 is the date of disability for purposes of claimant's entitlement to temporary disability.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved. Finally, claimant's attorney is also entitled to 25 percent of the interim compensation granted by this order, not to exceed $3,800.

ORDER

The Referee's order dated May 10, 1993 is reversed. The insurer's "de facto" denial of claimant's aggravation claim is set aside. The claim is remanded to the insurer for processing in accordance with law, including the payment of interim (temporary disability) compensation from May 12, 1992 through the date of hearing unless termination is otherwise authorized by law prior to the date of hearing. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the insurer. Claimant's attorney is also awarded 25 percent of the interim compensation granted by this order, not to exceed $3,800, payable directly to claimant's attorney by the insurer.

June 30, 1994 Cite as 46 Van Natta 1297 (1994)

In the Matter of the Compensation of
NICK SHEVCHYNSKI, Claimant
WCB Case Nos. 90-05141 & 90-12106
ORDER ON RECONSIDERATION (REMANDING)
James W. Moller (Saif), Defense Attorney

On June 22, 1994, we filed with the Court of Appeals a Notice of Withdrawal of our September 16, 1993 Order on Review (Nick Shevchynski, 45 Van Natta 1745 (1993)). See ORS 183.482(6); ORAP 4.35. We took such an action to reconsider our decision that affirmed the Referee's order dismissing claimant's request for hearing based on an allegedly unjustifiable delay. On reconsideration, the issue is the propriety of the Referee's dismissal order. After conducting our reconsideration, we replace our prior order with the following order.

FINDINGS OF FACT

Claimant requested a hearing on contested medical billings and the SAIF Corporation's denial of treatment for low back strain and depression. Claimant's case has been set for hearing several times since 1990. Claimant has been represented by various lawyers who have ultimately withdrawn. Several postponements were allowed in order to give claimant additional time to obtain representation. Claimant proceeded pro se.

In contrast, Dr. Thomas' April 9, 1992 request for surgery indicated that claimant was incapacitated with shoulder pain and that her range of motion in the shoulder was very limited. Dr. Thomas' May 12, 1992 operative report indicated that he found scarring of the bursa in the subacromial region. He performed a bursectomy, removed part of the acromion, and incised the coracoacromial ligament. (Ex. 41). Furthermore, he indicated that claimant was unable to work, whereas prior to surgery, claimant was working two hours per day and was capable of working in the sedentary range. (Cf. Exs. 40 and 44).

Consequently, we conclude that claimant's condition had changed so as to create a new set of operative facts that could not have been litigated at the hearing on January 9, 1992. Liberty Northwest Insurance Corp. v. Bird, supra. Furthermore, the medical evidence indicates that claimant's underlying condition had worsened and that she sustained diminished earning capacity. ORS 656.273(1); Smith v. SAIF, supra; Lucas v. Clark, supra.

In order to show that a previous award of permanent disability contemplated waxing and waning of symptoms, there must be medical evidence existing at the time of the award predicting such flare-ups; it is not sufficient that claimant has a history of exacerbations. See Lucas v. Clark, supra, 106 Or App at 691. Here, we conclude that none of the medical evidence existing at the time of the last arrangement of compensation predicted that claimant would experience waxing and waning of symptoms. Therefore, because waxing and waning of symptoms were not contemplated at the time of the last arrangement of compensation, ORS 656.273(8) is not applicable.

In conclusion, we find that claimant showed she sustained a worsening of her underlying condition resulting in diminished earning capacity. Furthermore, we find that claimant showed that her condition had changed so as to create a new set of operative facts that could not have been litigated at the hearing on January 9, 1992. Finally, claimant need not show that this worsening was greater than any prior waxing and waning since the previous award of permanent disability did not contemplate any future exacerbations. Therefore, we conclude that claimant proved a compensable aggravation claim.

Furthermore, we conclude that the doctrine of res judicata does not apply here to bar claimant's aggravation claim. In the absence of the proposed surgery, the Board had concluded in its prior order that the record did not establish that claimant's then-current right shoulder condition represented a worsening of her compensable condition. Reyes-Cruz, supra. Such a conclusion should not be interpreted as a holding that, in the event claimant underwent surgery as a result of her compensable condition, such a procedure could not result in a compensable aggravation claim. See, e.g., Deborah G. Portenier, 45 Van Natta 1593 (1993).

Consequently, based on the present record (the one that was developed subsequent to the first aggravation claim), we have concluded that claimant's compensable condition has worsened. Furthermore, the insurer's analogy to Ronald L. Ziemer, 44 Van Natta 1769 (1992), is inapposite, in that the claimant in Ziemer, unlike claimant in this case, had failed to establish that his condition had changed so as to have created a new set of operative facts that previously could not have been litigated.

Interim Compensation

The Referee declined to award claimant interim compensation subsequent to May 12, 1992, on the basis that the insurer had not received a medical verification of claimant's inability to work or objective medical findings that her condition had worsened. We disagree.

Claimant's entitlement to interim compensation in the form of temporary total disability benefits depends on whether the employer received notice or knowledge of a medically verified inability to work in a medical report that constitutes prima facie evidence in the form of objective findings that claimant's compensable condition had worsened. See ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993).

We conclude that by May 28, 1992, the insurer had sufficient notice of claimant's medically verified inability to work due to a compensable worsening. On that date, the employer had the following documents in its possession: (1) Dr. Thomas's letter of April 9, 1992, in which he indicated that claimant was unable to work and had failed in an attempt to return to work because of shoulder pain, that her condition had not improved with the passage of time, that her pain recurred with forward flexion and abduction past 90 degrees, that she had pain over the cromion, reduced range of motion and

Meanwhile, on April 9, 1992, Dr. Thomas again requested authorization for surgery. He indicated that claimant was unable to work, that her range of motion was reduced, and that conservative treatment had not been successful in treating her condition. (Ex. 40). On May 12, 1992, Dr. Thomas performed the surgery. He found scarring of the bursa at the subacromial region. He performed a bursectomy, removed a portion of the acromion, and incised the coracoacromial ligament. (Ex. 41).

Dr. Thomas released claimant to sedentary work with limitations on May 18, 1992, although he continued to treat her through November 30, 1992. (Exs. 42, 43 and 45). Claimant did not return to work.

On January 11, 1993, claimant's attorney requested the insurer to reopen claimant's claim as an aggravation and pay interim compensation, based on the May 12, 1992 operative report by Dr. Thomas. (Ex. 46).

CONCLUSIONS OF LAW AND OPINION

The Referee did not address the aggravation issue. Inasmuch as claimant raised the issue of a de facto denial of aggravation at hearing (Tr. 2) and on Board review (Cl. brief at 1 and 2), we begin our review with this issue.

Aggravation

Claimant contends that her condition worsened and that she was unable to work subsequent to May 12, 1992, the date surgery was performed on her shoulder. The insurer contends that the doctrine of res judicata applies to bar claimant from making a new claim for aggravation based on the performance of surgery, inasmuch as the surgery had been requested as part of her first claim for aggravation.

In order to establish a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. See Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Furthermore, because claimant has received a previous permanent disability award for her injury, she must establish that any worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8). In addition, because the November 24, 1992 Order on Review upheld the August 27, 1991 aggravation denial, claimant must show that her condition had changed so as to create a new set of operative facts that could not have been litigated at the January 9, 1992, hearing. Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560, rev den 309 Or 645 (1990).

Prior to claimant's last award of compensation, Dr. Hermens, claimant's then-attending physician, concurred with Drs. Brown and Geist's closing examination, in which they found the ranges of right shoulder motion to be 90 degrees of abduction, 10 degrees of adduction, 130 degrees of flexion, 35 degrees extension, 70 degrees of external rotation and 45 degrees of internal rotation. (Ex. 15). They released claimant to light work with restrictions and opined that claimant needed no further treatment. (Exs. 15, 39 and 44).

Although claimant continued to receive treatment for her shoulder and was diagnosed with an impingement syndrome (frozen shoulder) for which Dr. Thomas requested surgery, the Board concluded that claimant had not experienced an aggravation prior to the first hearing. The Board found that claimant continued to experience the same problems and experienced similar relief from her symptoms after receiving injections as she had prior to the Determination Order. They also concluded that, following claim closure, claimant's ability to work had improved, in that she was now able to work two hours per day and was capable of working in the sedentary range, whereas she had been able to work only on a sporadic, part-time basis of approximately two hours per week. The Board concluded that her condition had not changed since closure and that she had failed to prove that she was less able to work after the time of the Determination Order. Reyes-Cruz, supra.

Here, the record establishes a clear and unbroken line of complaints regarding claimant's right shoulder complaints that did not exist at all until claimant was injured in August 1987. In light of that evidence, I would conclude that, reading the record as a whole and in a reasonable light, Dr. Griffin's report supports the proposition that claimant's August 1987 injury caused a permanent disability of her right shoulder. On that basis, I would then conclude that claimant has met her burden of establishing that her August 1987 injury was at least a material contributing cause of her right shoulder condition.

My fear is that the Board has somehow changed the benchmarks for meeting the "material contributing cause" standard. The Board now appears to require claimants to carry that burden and to be "syntactically correct." That new standard escaped my notice during my last reading of ORS 656.266. Therefore, I respectfully dissent.

June 30, 1994 Cite as 46 Van Natta 1294 (1994)

In the Matter of the Compensation of
FILOGONIA REYES-CRUZ, Claimant
WCB Case No. 93-00471
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Crumme's order that: (1) did not set aside the insurer's "de facto" denial of her aggravation claim for a right shoulder condition; and (2) denied her interim compensation. On review, the issues are aggravation and interim compensation. We reverse.

FINDINGS OF FACT

Claimant compensably injured her right shoulder on November 30, 1989. The insurer accepted a thoracic and cervical strain/sprain. (Ex. 3). An April 2, 1991 Determination Order closed the claim and awarded 15 percent unscheduled permanent disability, which was later increased to 21 percent by a prior referee. That referee made findings that claimant experienced a 9 percent value for impairment based on a loss of range of motion and that she had been released to restricted light work. (Exs. 17, 39 and 44).

On April 26, 1991, claimant changed her attending physician to Dr. Thomas, M.D. He noted that claimant had full range of motion in the right shoulder, but pain with forward flexion and abduction past 90 degrees and anterior pain over the acromion. He diagnosed an impingement syndrome and treated claimant with a trigger point injection. (Exs. 20 and 21). Claimant continued to have pain in the shoulder. Dr. Thomas treated her condition with further trigger point injections and physical therapy. (Exs. 21 and 22).

On July 25, 1991, Dr. Thomas opined that claimant's condition had worsened since January 14, 1991, and informed the insurer that claimant might require acromioplasty surgery. (Ex. 23). On August 20, 1991, Drs. Brown, neurologist and Geist, orthopedic surgeon, examined claimant for the insurer. They opined that claimant's condition had not worsened. (Ex. 28). On August 27, 1991, the insurer denied claimant's aggravation claim. (Ex. 29).

On September 17, 1991, after ruling out a rotator cuff tear, Dr. Thomas requested authorization for acromioplasty surgery. (Ex. 32). He opined that claimant's right shoulder impingement syndrome was caused by her compensable injury. (Ex. 33). On October 12, 1991, Drs. Wilson, neurologist, and Neufeld, orthopedic surgeon, examined claimant for the insurer. They opined that claimant's condition had not worsened and that her pain complaints were merely subjective. (Ex. 35). On November 11, 1991, Dr. Thomas disagreed with the examiners and informed the insurer that claimant was unable to work, was not medically stationary, and was a candidate for a Neer acromioplasty. (Ex. 36).

A hearing was held on January 9, 1992. In a March 17, 1992 Opinion and Order, a prior referee concluded that claimant had established an aggravation of her compensable right shoulder injury. (Ex. 39). On November 24, 1992, the Board reversed on the basis that claimant's condition had not worsened since claim closure and she failed to prove that she was less able to work than at the time of the Determination Order. Filogonia Reyes-Cruz, 44 Van Natta 2349 (1992).

An attorney fee may be awarded under ORS 656.382(1) if an insurer unreasonably resists the payment of compensation. Because we have determined that claimant's right shoulder condition is not compensable, it follows that SAIF did not unreasonably resist the payment of compensation. Accordingly, claimant is not entitled to an attorney fee under ORS 656.382(1).

We reach the same conclusion regarding claimant's ORS 656.386(1) argument. To be entitled to an attorney fee under that statute, claimant must have "finally prevailed" on SAIF's denial of claimant's right shoulder condition. Although we concluded that claimant had perfected a claim for that condition, we ultimately determined that the claim was not compensable. Therefore, claimant has not "finally prevailed" on SAIF's "de facto" denial of her right shoulder condition. For this reason, we conclude that claimant is not entitled to an attorney fee under ORS 656.386(1).

Reasonableness of Attorney Fee -- Lumbar Strain Claim

We adopt the Referee's award of $1,000 attorney fee award for claimant's counsel's assistance in setting aside SAIF's "de facto" denial of claimant's lumbar strain claim. See OAR 438-15-010(4).

ORDER

The Referee's order dated June 1, 1993 is affirmed.

Board Member Gunn, dissenting.

The majority concludes that claimant has failed to prove the compensability of her right shoulder condition, even though one of the consulting physicians concluded that that condition was related to claimant's August 1987 injury. I agree with the majority that, because claimant's theory is that her right shoulder condition was the direct result of the August 1987 accident, claimant need only establish that the accident was a material contributing cause of her shoulder injury. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). However, I disagree with the majority's conclusion that claimant has not met that burden.

The record conclusively establishes that claimant consistently complained about her right shoulder after the August 1987 accident. Claimant's original "801" form indicated that, at the time of the accident, claimant pulled her back and shoulder. (Ex. 1). In December 1987, she complained to Dr. Martens, examining physician, of "some pain in her right shoulder." (Ex. 6-1) (emphasis added). In a 1989 cervical spine evaluation, claimant reported a burning sensation from her right neck to shoulder blade. (Ex. 8-1). Subsequently, on a March 1989 "827" form, Dr. Duewel, one of claimant's treating physicians, noted that claimant had pain in her right shoulder and shoulder blade, which Duewel diagnosed as tendonitis and bursitis. (Ex. 9). Thereafter, Dr. Duewel declined to render an opinion regarding the cause of claimant's right shoulder condition, because she did not have access to claimant's medical records. (Ex. 11-2). However, Dr. Griffin, the physician to whom Dr. Duewel referred claimant, did render an opinion regarding causation, concluding that claimant's shoulder condition was related to her August 1987 injury. (See Ex. 23BB).

The majority misconstrues Dr. Duewel's final "opinion." Because Dr. Duewel refused to reach a conclusion regarding the cause of claimant's right shoulder for a non-medical reason -- unavailability of medical records -- I would characterize the report as a "non-opinion." The majority blatantly elevates form over substance when it concludes that Dr. Duewel's cautious "non-opinion" is evidence of the noncompensability of claimant's condition. In doing so, the majority has turned that "non-opinion" into affirmative evidence against claimant. Because the "non-opinion" is just that -- nothing -- I would conclude that it neither helps nor hurts claimant.

The majority goes even further astray when it discounts Dr. Griffin's opinion. Dr. Griffin agreed that claimant had a permanent disability of her back, neck or shoulder as a result of her 1987 injury. (Ex. 23BB-1). The majority concludes that, because that language is phrased disjunctively, and because Griffin only elaborated about claimant's low back condition, Griffin's report is insufficient to meet claimant's burden of proof.

I take exception to the majority's unusually exacting reading of Dr. Griffin's report. It is this Board's duty to read the record as a whole and in a reasonable light to determine whether a claimant has met his or her burden of proof. I believe that requiring claimants, and their witnesses, to be syntactical experts is unreasonable, and hence, is an abdication of that duty.

October 30, 1992 Aggravation Denial

We adopt the Referee's conclusions regarding SAIF's October 30, 1992 aggravation denial, with the following supplementation.

Claimant asserts that, on or about July 31, 1992, the day on which she allegedly reinjured her back lifting sand bags, she experienced a worsening of her original compensable condition. We disagree.

The preponderance of the medical evidence establishes that claimant's compensable condition did not worsen in July 1992. Drs. Tesar and Wilson, who examined claimant on SAIF's behalf, found no objective findings to substantiate a material worsening of claimant's condition as a result of her July 31, 1992 work incident. (Ex. 25-6). Dr. Eidenberg, treating physician, concurred with that conclusion. (Ex. 27). Finally, Drs. Fry and Ziven, who also examined claimant on SAIF's behalf, noted that, although claimant's condition had worsened by history, there were no objective findings on examination to support a worsening. (Ex. 29-5).

The only evidence that even remotely supports a worsening of claimant's condition in July 1992 is Dr. Griffin's August 20, 1992 "check-the-box" report. In that report, Dr. Griffin agreed with claimant's counsel that claimant's condition had materially worsened since closure. (Ex. 23BB-1). However, because Dr. Griffin apparently stopped treating claimant in September or October 1992 (see Exs. 14-16), and, because we have found no evidence in the record that Dr. Griffin was apprised of the details regarding claimant's July 31, 1992 work incident, we give his opinion minimal probative weight. See Somers v. SAIF, 77 Or App 259 (1986).

On this record, we agree with the Referee that claimant has failed to establish that her compensable condition worsened in July 1992.

Penalties -- Failure to Close 1987 Claim

We adopt the Referee's conclusions regarding SAIF's failure to close claimant's nondisabling 1987 claim, with the following supplementation.

Claimant argues that, although SAIF accepted her 1987 injury claim as nondisabling, in light of medical evidence that subsequently developed in 1987, SAIF should have reclassified the injury as disabling. We disagree.

If claimant disagreed with SAIF's classification of her injury claim, she had one year from the date of injury to request a reclassification. Former ORS 656.262(12) (since amended by Or Laws 1990, ch 2, § 15). Because claimant did not timely request that her 1987 claim be reclassified, we will not consider her reclassification argument now.

Penalties and Related Attorney Fees -- Alleged Unreasonable Denials

We adopt the Referee's conclusions regarding penalties related to SAIF's allegedly unreasonable denials, with the following modification.

Because we have concluded that SAIF "de facto" denied claimant's right shoulder claim, we must determine whether claimant is entitled to a penalty or related attorney fee. We conclude she is not.

Because SAIF did not accept or deny claimant's right shoulder claim within 90 days, a penalty may be assessed under ORS 656.262(10), if there were amounts then due between the date when the acceptance or denial should have been issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). If there were no amounts then due, there is no basis for a penalty. See Wacher Siltronic v. Satcher, 103 Or App 513 (1990). Because we have concluded that claimant's right shoulder condition was not compensable, there were no amounts then due on which to base a penalty. Id.

Claimant asserts that she is entitled to an attorney fee under ORS 656.382(1) and ORS 656.386(1). We disagree.

Although Dr. Goldmann mentioned one possible course of treatment for claimant's depression, he did not request or prescribe any specific treatment for that condition. Indeed, he specifically declined to recommend treatment, because he felt that claimant was not "psychologically oriented." Because Dr. Goldmann's report did not request or prescribe any medical treatment for claimant's depression, we conclude that the report did not constitute a claim. See Safeway Stores, Inc. v. Smith, supra.

Alleged "De Facto" Denial of November 1991 Aggravation Claim

We adopt the Referee's conclusions regarding SAIF's alleged "de facto" denial of claimant's November 1991 aggravation claim, with the following supplementation.

Claimant argues that a November 19, 1991 "827" form signed by Dr. Eidenberg, one of claimant's treating physicians, and Dr. Eidenberg's November 26, 1991 request for palliative care, constitute a perfected aggravation claim. (Exs. 18, 20A). We disagree.

Dr. Eidenberg's "827" form lists claimant's date of injury as August 24, 1987, and claimant's diagnosis as "back pain." (Ex. 18). Dr. Eidenberg's November 26 request for palliative care states that claimant's work capability would decrease if the requested treatment was not provided, and that claimant's injury remained the major contributing cause of claimant's continued need for care. (Ex. 20A-1).

Assuming, without deciding, that those documents satisfy the causation requirement of an aggravation claim, see Dixie L. Tucker, supra, we nevertheless conclude that they do not constitute an aggravation claim, because they do not contain any objective findings that claimant's compensable condition had medically worsened. Juan F. Carrizales, supra; see ORS 656.273(1), (3).

October 29, 1992 New Injury Denial

The Referee concluded, inter alia, that because there was no evidence that claimant required treatment for her alleged new back injury, SAIF properly denied claimant's new injury claim. We agree with the Referee's reasoning, with the following supplemental analysis.

On July 31, 1992, claimant experienced a "catch" in her back while lifting flats of sand at work. (Tr. 15). Thereafter, she filed an "801" form, listing her injury as "pulled back and hips." (Ex. 23A). SAIF denied that claim on the ground that claimant had not sustained a new injury. (Ex. 25A).

It is claimant's burden to establish that she sustained a new injury. See ORS 656.005(7)(a); ORS 656.266; see also Daniel L. Hakes, 45 Van Natta 2351 (1993). She has not met that burden.

In an October 9, 1992 report, Dr. Eidenberg, claimant's treating physician, stated that he could not find any reference to a July 31, 1992 injury in his records. (Ex. 24-1). He further stated that, during an August 5, 1992 appointment with him, claimant failed to mention a specific new injury. (Id.)

Drs. Tesar and Wilson examined claimant on SAIF's behalf on October 28, 1992. (Ex. 25). After reviewing claimant's history and radiological data and performing a physical examination, the doctors diagnosed lower back strain, by history, without objective orthopedic or neurologic findings. (Id. at 5). They concluded that claimant had not sustained a new injury on July 31, 1992; rather, they believed that she continued to experience a waxing and waning of the symptoms she had had since her August 1987 injury. (See Ex. 25-6). Dr. Eidenberg, claimant's treating physician, concurred with Drs. Tesar's and Wilson's report. (Ex. 27).

In light of claimant's prior back complaints and previous injury, we find this issue medically complex. Consequently, we require expert medical opinion to resolve it. See Uris v. Compensation Department, 247, Or App 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). The parties' experts agree that claimant did not sustain a new injury in July 1992. Moreover, during an appointment shortly after the alleged reinjury date, claimant failed to apprise her treating physician of any new injury. For these reasons, we conclude that claimant has not established that she sustained a new injury and, therefore, that SAIF properly denied claimant's new injury claim.

Dr. Duewel's March 1989 "827" report lists the date of injury as August 24, 1987, and identifies claimant's diagnosis as "tendonitis, bursitis r[ight] shoulder, back" and "thoracic strain." (Ex. 9). We will assume, without deciding, that the reference to the date of claimant's original work accident is prima facie evidence that there is a causal connection between her shoulder condition and the accident. Nevertheless, we conclude that the "827" form does not constitute an aggravation claim because it lacks any statement or findings that suggest that claimant's compensable condition had medically worsened. Juan F. Carrizales, supra; see ORS 656.273(1), (3).

Alleged "De Facto" Denial of April 1990 Aggravation Claim

We adopt the Referee's conclusions with respect to SAIF's alleged "de facto" denial of claimant's April 1990 aggravation claim, with the following supplementation.

Claimant relies on Dr. Griffin's September 1989, April 1990 and August 1992 medical reports as support for her assertion that SAIF "de facto" denied an April 1990 aggravation claim. (Exs. 12, 12A, 23BB). In the 1992 report, a "check-the-box" letter drafted by claimant's counsel, Dr. Griffin agreed that claimant had a permanent disability of her back, neck or shoulder as a result of her August 1987 compensable injury. (Ex. 23BB-1). Griffin also agreed that claimant's condition had materially worsened. (Id.)

We conclude that Dr. Griffin's reports are of little assistance to claimant's cause. First, the 1989 and 1992 reports concerned claimant's condition in 1989 and 1992, not 1990. Second, although Dr. Griffin's 1992 report states that claimant's compensable condition had worsened, it does not include any objective findings to support the bare assertion of worsening. See Juan F. Carrizales, supra; see ORS 656.273(1), (3). For these reasons, we conclude that Dr. Griffin's 1989 and 1992 reports do not constitute a claim for an April 1990 aggravation.[2]

We reach the same conclusion regarding Dr. Griffin's April 1990 report. The report states that claimant had returned to Griffin for treatment for what Griffin believed was lumbar strain related to claimant's 1987 work injury. (Ex. 12A). Griffin stated that the condition was gradually improving. (Id.) Because the report lacks any statement or findings suggesting that claimant's compensable condition had medically worsened in April 1990, we conclude that it does not constitute an aggravation claim. Juan F. Carrizales, supra; see ORS 656.273(1), (3).

For the foregoing reasons, we conclude that claimant did not perfect an aggravation claim in April 1990.

Alleged "De Facto" Denial of Depression Claim

We adopt the Referee's conclusions with respect to SAIF's alleged "de facto" denial of claimant's depression claim, with the following supplementation.

As we stated earlier, a physician's report requesting or prescribing medical treatment constitutes a claim. See ORS 656.005(6) and (8); see also Safeway Stores, Inc. v. Smith, supra. Claimant argues that a May 6, 1992 report of Dr. Goldmann, examining psychologist, constitutes a claim for depression. We disagree.

In his report, Dr. Goldmann stated:

> "Depression appears, however, to be a major problem here and one that would benefit from attention. [Claimant] does not appear to be particularly psychologically oriented, and consequently, an intervention of that kind is not recommended. However, it is possible that a more coordinated and gentle regime [sic] of physical therapy with some counseling could be of benefit." (Ex. 22A-2).

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[2] Claimant also relies on a September 1991 rehabilitation services report as evidence of an April 1990 aggravation. (Ex. 14). Again, because that report speaks to claimant's condition in September 1991, we do not consider it to be a claim for an aggravation in April 1990.

denied "de facto" if the insurer fails to accept or deny the claim within 90 days of notice or knowledge of the claim. See ORS 656.262(6); Barr v. EBI Companies, 88 Or App 132 (1987); Betti A. Haley, 46 Van Natta 205, on recon 46 Van Natta 520 (1994).

In March 1989, claimant consulted Dr. Duewel, who diagnosed "tendonitis, bursitis r[ight] shoulder, back" and "thoracic strain." (Ex. 9). Thereafter, Dr. Duewel completed an "827" form, listing that diagnosis, and the type of treatment provided to claimant as "medical evaluation." (Id.) In a June 20, 1989 report, Dr. Duewel indicated that she had also prescribed physical therapy and Naprosyn for claimant's right shoulder condition. (Ex. 11).

We conclude that Dr. Duewel's reports constituted a claim for right shoulder tendonitis and bursitis. See Safeway Stores, Inc. v. Smith, supra. Those reports specifically refer to a right shoulder condition. Moreover, they reveal that Dr. Duewel prescribed treatment for that condition. We conclude that those reports were sufficient to put SAIF on notice of a claim for a right shoulder condition.

A separate inquiry is whether claimant's right shoulder condition is compensable. Claimant's theory at hearing was that her right shoulder condition was the direct result of her August 1987 work accident. (Tr. 5). To prevail on a direct injury theory, the claimant must establish that her August 1987 accident was a material contributing cause of her injury. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We conclude that claimant has failed to meet her burden of proof.

Because she did not have access to claimant's 1987 medical records, Dr. Duewel was unable to relate claimant's right shoulder condition to claimant's original injury. (Ex. 11). Dr. Duewel referred claimant to Dr. Griffin, who concluded that claimant had a lumbar strain that was related to her 1987 work accident. (Exs. 12, 12A). In an August 20, 1992 "check-the-box" report, Dr. Griffin agreed with claimant's counsel's assertion that "claimant ha[d] permanent disability in her back, neck or shoulder as a result of the 8/14/87 injury." (Ex. 23BB-1). However, in summarizing claimant's disability in his own words, Dr. Griffin focused solely on claimant's back pain. (Id.)

We conclude that this evidence fails to establish the requisite causal connection between claimant's right shoulder condition and her 1987 work injury. Dr. Duewel was unable to render any opinion regarding causation. Furthermore, the gist of Dr. Griffin's opinion is that claimant had sustained a permanent disability of her back, neck or shoulder; it does not address, in any detail, the specific cause of claimant's back, neck or shoulder conditions. (It says only that those conditions were the "result of the 8/14/87 injury." (Ex. 23BB-1).) On that ground alone, we question the dissent's reliance on Dr. Griffin's report as proof of the compensability of claimant's right shoulder condition.

We find other reasons to discount Dr. Griffin's report. Because Dr. Griffin agreed that claimant's "back, neck or shoulder" condition was causally related to claimant's August 1987 injury, and because his summary focused on claimant's back pain alone, we conclude that Dr. Griffin did not render an opinion regarding the cause of claimant's shoulder condition. In any event, Dr. Griffin's report is so conclusory as to prevent us from engaging in any meaningful review. See Moe v. Ceiling Systems, 44 Or App 429 (1980). On this record, we conclude that claimant has failed to establish the compensability of her right shoulder condition.

Alleged "De Facto" Denial of March 1989 Aggravation Claim

We adopt the Referee's conclusions with respect to SAIF's alleged "de facto" denial of claimant's March 1989 aggravation claim, with the following supplementation.

Claimant argues that Dr. Duewel's March 1989 "827" report constituted a perfected aggravation claim. We disagree.

A physician's report may establish an aggravation claim. See Safeway Stores, Inc. v. Smith, supra. However, to constitute an aggravation claim, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Juan F. Carrizales, 43 Van Natta 2811 (1991); see ORS 656.273(1), (3). Moreover, the report must establish, at least prima facie, a causal connection between claimant's noted condition and the compensable injury. Dixie L. Tucker, 45 Van Natta 795 (1993).

While I recognize that Dr. Barnhouse opined that claimant's low back strain in August 1992 was separate from and unrelated to her accepted low back strain, I do not find his opinion persuasive, considering the record as a whole. Where, as here, the same body part (low back) and mechanism of injury (strain) are involved, I do not find the conditions to be readily separable. Dr. Barnhouse acknowledged that claimant was only about 80-90 percent improved when she was released to regular work. (Ex. 30 at 21-22). Claimant testified that her back continued to flare up occasionally. (Tr. 5). Under such circumstances, I am not persuaded that claimant's August 1992 low back strain is separable from her accepted low back strain. Therefore, I would set aside the insurer's partial denial as an invalid preclosure denial.

In the Matter of the Compensation of
EMILY P. REED, Claimant
WCB Case Nos. 92-14484 & 92-11014
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's alleged "de facto" denial of a right shoulder condition; (2) upheld SAIF's alleged "de facto" denial of a March 1989 aggravation claim; (3) upheld SAIF's alleged "de facto" denial of an April 1990 aggravation claim; (4) upheld SAIF's alleged "de facto" denial of a depression claim; (5) upheld SAIF's alleged "de facto" denial of a November 1991 aggravation claim; (6) upheld SAIF's October 29, 1992 denial of a July 31, 1992 new injury claim; (7) upheld SAIF's October 30, 1992 denial of an aggravation claim; (8) declined to assess a penalty for SAIF's allegedly unreasonable failure to close claimant's 1987 claim; (9) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable denials; and (10) awarded claimant a $1,000 attorney fee for overturning SAIF's "de facto" denial of a lumbar condition. On review, the issues are compensability, aggravation, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

On September 2, 1987, SAIF accepted claimant's thoracic/ cervical strain. (Ex. 3).

In his April 23, 1990 letter to SAIF, Dr. Griffin, consulting physician, opined that claimant had a lumbar strain that was the result of her August 24, 1987 injury. (Ex. 12A).

CONCLUSIONS OF LAW AND OPINION

Alleged Right Shoulder "De Facto" Denial

The Referee upheld SAIF's alleged "de facto" denial of claimant's right shoulder condition on the grounds that claimant had failed to make a right shoulder claim and, alternatively, that the medical evidence had failed to establish that claimant had suffered a compensable right shoulder injury.[1] We agree with the latter, but not the former, conclusion.

A claim is "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which the subject employer has notice or knowledge." ORS 656.005(6). A physician's report requesting or prescribing medical treatment constitutes a claim. See ORS 656.005(6) and (8); see also Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992). A claim is

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[1] The Referee characterizes the alleged right shoulder "de facto" denial as a 1987 denial. Based on our reading of claimant's appellate brief, we understand claimant to be asserting that SAIF "de facto" denied her right shoulder condition either in 1987 or 1989. Because we have concluded that claimant's 1987 "de facto" denial arguments are without merit, we address only her 1989 arguments.

In the Matter of the Compensation of
ZORA A. RANSOM, Claimant
WCB Case No. 92-16312
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes, Westerband, and Hall.

Claimant requests review of Referee Davis' order which upheld the insurer's partial denial of claimant's current low back condition. On review, the issue is compensability.

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

Claimant contends that the denial must be set aside because it is an invalid preclosure denial, prohibited by Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984). We disagree because we do not find the Roller holding applicable in this case.

In Roller, the employer accepted responsibility for claimant's diabetes mellitus condition. Subsequently, it attempted to deny future responsibility for the same condition, before determining the extent of claimant's disability. The court held that the employer had issued an improper preclosure denial of the same condition it had previously accepted, thereby bypassing the orderly claim closure procedure for the accepted condition.

Here, although the denial issued two days before the Determination Order closing claimant's accepted low back claim, there is no medical evidence that the denied low back strain of August 1992 is the same as, or even related to, the accepted strain for which claimant last treated in August 1991. Although both claims involved a low back strain condition, they did not involve the same strain condition. On the contrary, claimant's treating physician, Dr. Barnhouse, unequivocally stated that the August 1992 strain was unrelated to her accepted low back strain, and was a "new" strain condition. (See Exs. 22, 25, 29, and 30 at 7-12).

Under such circumstances, we find that the employer's denial does not constitute an impermissible preclosure denial of an accepted condition. The dissent's arguments to the contrary are not supported by any medical evidence. Because the medical evidence demonstrates that claimant's current low back strain is a new strain condition, unrelated to her compensable strain, the Roller rule against preclosure denials is not applicable.[1]

ORDER

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

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[1] Neither is the court's recent decision in United Airlines, Inc. v. Brown, 127 Or App 253 (1994), applicable. In Brown, the court held that the language of ORS 656.005(7)(a)(B), which provides that, if a compensable injury combines with a preexisting disease or condition, "the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment," does not provide the procedural authority to deny an accepted claim. Instead, the appropriate procedure is claim closure under ORS 656.268. 127 Or App at 256-57. Here, however, the insurer's denial of a new low back strain condition is not based on the presence of a preexisting condition or on the terms of ORS 656.005(7)(a)(B). No preexisting disease or condition is involved in this case. Therefore, the insurer's denial does not contravene the court's decision in Brown.

Board Member Hall dissenting.

Because I believe the insurer's partial denial must be set aside as an invalid preclosure denial, I dissent.

A carrier may not issue a partial denial of a previously accepted inseparable condition while the claim remains open. Guerrero v. Stayton Canning Co., 92 Or App 209, 212 (1988), citing Roller v. Weyerhaeuser Co., supra; Safstrom v. Riedel International, Inc., 65 Or App 728, rev den 297 Or 214 (1983). That is what the insurer did here. Therefore, the denial must be set aside.

Claimant objects to the Referee's statement that she received the sum of $1,200 for giving up her rights. Claimant has misinterpreted the Referee's finding. The Referee never stated that she received $1,200; instead, the Referee said that was the amount agreed to in the proposed Claim Disposition Agreement (CDA) that claimant later sought Board disapproval. In accordance with claimant's request, the Board set the CDA aside on June 24, 1992. (Ex. 37). Thus, claimant never received the $1,200.

Claimant also contends that she was told when she signed the settlement papers she would still have her medical rights and that all her medical bills would be paid. Such an understanding is consistent with the notice required with the CDA, i.e., that pursuant to ORS 656.236 the parties agreed to settle the claim except for medical services. (Ex. 36). In any event, claimant is entitled to medical benefits arising from her compensable November 1987 thoracic/sacroiliac sprain and bilateral carpal tunnel syndrome. See ORS 656.245. However, claimant has not proven a causal relationship to her current conditions, particularly in light of the April 1992 DCS which upheld the August 1991 denial of claimant's cervical, thoracic, lumbar and sacroiliac conditions, including lumbar degenerative changes and disc disease, lumbar spondylolysis, osteophytes, spina bifida occulta, disc herniation at L5-S1, dorsal degenerative changes, headaches, bilateral carpal tunnel syndrome, trigger finger on the right hand, connective tissue disorder and arthritis of both hands.

Finally, claimant argues that she did not request a hearing for the December 7, 1992 denial because she was told by the Workers' Compensation Board that her appeal would be handled with her hearing on the case and she assumed that the whole case would be handled together. The December 7, 1992 denial denied her claims for current right hand condition, including right ring finger triggering and right carpal tunnel syndrome and low back condition. (Ex. 46).

ORS 656.319(1)(a) requires a claimant to request a hearing within 60 days of notification of the denial. Good cause must be established by claimant if a hearing request is filed after the 60th day, but not later than 180 days after the notification of denial. ORS 656.319(1)(b). Here, claimant had actual notice of the December 7, 1992 denial. There is no evidence that claimant requested a hearing on that denial until the date of the hearing, on August 25, 1993. Because the hearing request was received more than 180 days after the date of denial, the "good cause" exception of ORS 656.319(1)(b) does not apply. See Richard I. Bowe, 41 Van Natta 1754 (1989). Thus, the Referee properly concluded that the Hearings Division lacked authority to consider the December 7, 1992 denial.

Alternatively, we agree with the Referee that, even if SAIF's December 7, 1992 denial had been timely appealed, claimant would not be entitled to any relief because the previous denial of all her conditions was upheld in the DCS of April 9, 1992. First, the record supports a finding that a bona fide dispute existed at the time of settlement to support the DCS. Secondly, the record does not demonstrate that claimant's current conditions are different than the conditions denied in August 1991. Consequently, we find that there are no extraordinary circumstances to justify setting aside the DCS.

In conclusion, we recognize claimant's frustrations with the workers' compensation system and her prior legal counsel. Nevertheless, for the reasons expressed in the Referee's decision, as well as the reasoning expressed herein, she has not established that she is entitled to additional compensation for the disputed conditions. Should claimant have objections with her past legal representation, that is a matter between her and her prior attorney, not this forum.

ORDER

The Referee's order dated October 5, 1993 is affirmed.

triggered the Board's Own Motion order reopening his 1983 claim for the payment of temporary disability. Claimant's counsel has ably contributed to these results by submitting a cogent and concise respondent's brief which thoroughly addresses the relevant facts and applies the appropriate statutory and case precedents.[1]

The compensability dispute concerned legal and medical matters at a complexity level above most compensability issues that the Board considers on review. Likewise, the appellate arguments are at a higher level than those normally entertained by the Board. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After completing our reconsideration of this matter, we find that a reasonable fee for claimant's attorney's services on Board review concerning SAIF's denial is $2,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have also taken into consideration that claimant's attorney has also been awarded $500 under ORS 656.382(1) for SAIF's unreasonable claim processing, as well as an "out-of-compensation" fee payable from claimant's temporary disability (not to exceed $1,050) which was granted by the Board's Own Motion order.

Accordingly, we withdraw our June 6, 1994 order. On reconsideration, as modified herein, we adhere to and republish our June 6, 1994 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant postulates that a determination of a reasonable attorney fee includes consideration of the length of an appellate brief. (In other words, the longer the brief, the higher the fee). Such an interpretation would be inaccurate. The critical inquiry in evaluating the effectiveness of an appellate brief is whether the arguments advocated are presented in a clear, succinct, well-reasoned, and persuasive manner.

June 30, 1994 Cite as 46 Van Natta 1285 (1994)

In the Matter of the Compensation of
NANCY E. PETOCK, Claimant
WCB Case No. 92-12529
ORDER ON REVIEW
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Baker's order that: (1) found that claimant's hearing request from the SAIF Corporation's December 7, 1992 denial was untimely filed; (2) upheld SAIF's July 30, 1992 denial; and (3) found that the following conditions were not compensable: (a) a second right hand carpal tunnel surgery; (b) two low back surgeries; and (c) a consequential condition of the left leg and foot. On review, the issues are the timeliness of claimant's hearing request, the validity of a Disputed Claim Settlement (DCS) and, if the settlement is not valid, compensability.

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

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Settlements are to be encouraged within the limits of the statute; once approved, they should be set aside only if they clearly violate the statute. Kasper v. SAIF, 93 Or App 246, 250 (1988). In determining whether a settlement violates the statute, we exercise de novo review authority. Pruitt Watson, 45 Van Natta 1633 (1993). We regard setting aside an approved settlement to be an extraordinary remedy to be granted sparingly in the most extreme circumstances. Id.

WORKERS' COMPENSATION CASES

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Additional court cases from this period will appear in the next *Van Natta's* volume, July-September 1994. This quarter's inclusion has been shortened owing to space considerations.

Cite as 318 Or 614 (1994) April 14, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

S-W FLOOR COVER SHOP, Respondent on Review,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and SAIF CORPORATION, Petitioner on Review.
(DIF 90-10-009; CA A47356; SC S40585)

In Banc
On review from the Court of Appeals.*
Argued and submitted January 6, 1994.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioner on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Bruce D. Smith, Medford, argued the cause for respondent on review.
VAN HOOMISSEN, J.
The decision of the Court of Appeals is affirmed in part and reversed in part. The case is remanded to the Department of Insurance and Finance for further proceedings.
*Judicial review from the Department of Insurance and Finance. 121 Or App 402, 854 P2d 944 (1993).

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318 Or 616> This case requires the court to determine how the statutory definition of "independent contractor" found in ORS 670.600, enacted in 1989, has affected statutory provisions for determining when a person is subject to Oregon's workers' compensation law, ORS chapter 656.

SAIF Corporation, petitioner on review, asks this court to reverse the Court of Appeals' determination in this case that the legislative creation of a statutory definition of independent contractor replaced the judicially created "right to control" test for determining workers' compensation coverage. *See S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, 407, 854 P2d 944 (1993) (so holding). For the reasons that follow, the decision of the Court of Appeals is affirmed in part and reversed in part. The case is remanded to the Department of Insurance and Finance (DIF) for further proceedings.[1]

This case arose in the context of an audit dispute between S-W Floor Cover Shop (S-W Floor) and its insurer, SAIF, regarding how high a premium S-W Floor was to be charged for its workers' compensation insurance coverage. During the disputed period, July 1988 through June 1990, S-W Floor used the services of three carpet installers at issue in this case. SAIF issued workers' compensation insurance policies for those periods and included, as part of the basis for the premiums that it charged, the amounts paid to those carpet installers, on the belief that the carpet installers were subject workers under the workers' compensation law. *See* ORS 656.005(28) (defining "worker," quoted in text *infra*); ORS 656.027 (who are "subject workers," quoted in text *infra*).

S-W Floor appealed to DIF, arguing that the carpet installers were not workers subject to assessment, because they were independent contractors. DIF determined that, under the judicially created tests to determine whether one was an independent contractor and not subject to the **<318 Or 616/617>** workers' compensation law,[2] the three carpet installers were covered by the workers' compensation law before October 3, 1989, but that, under the ORS 670.600 statutory definition that took effect after that date, two of the installers were independent contractors not covered by workers' compensation law, but one was covered. S-W Floor petitioned the Court of Appeals for judicial review, and SAIF cross-petitioned for review. The Court of Appeals affirmed in part and reversed in part, remanding the case to DIF. *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra,* 121 Or App at 408.

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[1] This department since has been renamed the Department of Consumer and Business Services, but will be referred to as DIF throughout this opinion, because that was its name at the time it issued the order in this case.

[2] *See* explanation of judicially created test, discussed in text *infra* at 617.

SAIF sought review in this court of the portion of the Court of Appeals' decision pertaining to the period after October 3, 1989, arguing that the Court of Appeals misapplied the statutory definition of independent contractor found in ORS 670.600 in light of the provisions of ORS 656.005(28) (defining worker) and ORS 656.027 (listing exemptions for nonsubject workers). We allowed review to determine how the statutory definition of "independent contractor" and amendments to the workers' compensation law enacted in 1989 affect workers' compensation coverage.

In interpreting statutes, this court's task is to discern the intent of the legislature. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The statutory text is the starting point and the best evidence of legislative intent. *Ibid.* The court also considers rules of statutory construction that bear directly on how to interpret the text. *Id.* at 611. The context also is considered; it includes other provisions of the same statute, as well as other related statutes. *Ibid.* In examining context, the court also considers relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. Only if the intent of the legislature is unclear after consideration of the text and context of a statute does this court consider legislative history as evidence of the legislature's intent. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611-12.

318 Or 618> We turn to the text of the relevant statutes. ORS 670.600, relating to "independent contractors," was enacted in 1989, see Or Laws 1989, ch 762, 1, and provides:

> "As used in various provisions of ORS chapters 316 [revenue code], 656 [workers' compensation law], 657 [unemployment law] and 701 [construction contractors law], an individual or business entity that performs labor or services for remuneration shall be considered to perform the labor or services as an 'independent contractor' if the standards of this section are met:
>
> "(1) The individual or business entity providing the labor or services is free from direction and control over the means and manner of providing the labor or services, subject only to the right of the person for whom the labor or services are provided to specify the desired results;
>
> "(2) The individual or business entity providing labor or services is responsible for obtaining all assumed business registrations or professional occupation licenses required by state law or local government ordinances for the individual or business entity to conduct the business;
>
> "(3) The individual or business entity providing labor or services furnishes the tools or equipment necessary for performance of the contracted labor or services;
>
> "(4) The individual or business entity providing labor or services has the authority to hire and fire employees to perform the labor or services;
>
> "(5) Payment for the labor or services is made upon completion of the performance of specific portions of the project or is made on the basis of an annual or periodic retainer;
>
> "(6) The individual or business entity providing labor or services is registered under ORS chapter 701, if the individual or business entity provides labor or services for which such registration is required;
>
> "(7) Federal and state income tax returns in the name of the business or a business Schedule C or farm Schedule F as part of the personal income tax return were filed for the previous year if the individual or business entity performed labor or services as an independent contractor in the previous year; and
>
> "(8) The individual or business entity represents to the public that the labor or services are to be provided by an **<318 Or 618/619>** independently established business. Except when an individual or business entity files a Schedule F as part of the personal income tax returns and the individual or business entity performs farm labor or services that are reportable on Schedule C, an individual or business entity is considered to be engaged in an independently established business when four or more of the following circumstances exist:

"(a) The labor or services are primarily carried out at a location that is separate from the residence of an individual who performs the labor or services, or are primarily carried out in a specific portion of the residence, which portion is set aside as the location of the business;

"(b) Commercial advertising or business cards as is customary in operating similar businesses are purchased for the business, or the individual or business entity has a trade association membership;

"(c) Telephone listing and service are used for the business that is separate from the personal residence listing and service used by an individual who performs the labor or services;

"(d) Labor or services are performed only pursuant to written contracts;

"(e) Labor or services are performed for two or more different persons within a period of one year; or

"(f) The individual or business entity assumes financial responsibility for defective workmanship or for service not provided as evidenced by the ownership of performance bonds, warranties, errors and omission insurance or liability insurance relating to the labor or services to be provided."[3]

That definition, in and of itself, does not specify how it affects workers' compensation coverage for independent contractors.

ORS 656.005, the definition section of the workers' compensation law, provides in part:

"(28) 'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and **<318 Or 619/620>** appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant.

"(29) 'Independent contractor' has the meaning for that term provided in ORS 670.600."[4]

ORS 656.027 provides that all "workers" are subject to ORS chapter 656, unless they qualify as "nonsubject workers." Under the 1989 amendments to ORS 656.027, certain categories of exempt workers must qualify as "independent contractors" in order to be "nonsubject workers":

"All workers are subject to this chapter except those nonsubject 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.

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[3] This statute was codified as ORS 701.025 at the time of the DIF order in this case; it is currently codified as ORS 670.600 and is referred to as such throughout this opinion.

[4] Although the definition of "worker" currently found in subsection (28) has been a part of the law in essentially the same form since 1975, subsection (29) was added at the same time that ORS 670.600 was enacted. *See* Or Laws 1975, ch 556 (amending and recodifying definitions formerly found in ORS 656.002); Or Laws 1989, ch 762, 4.

"(8) Partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor.

"(9) Corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation subject to the following limitations:

"* * * * *

"(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor." ORS 656.027.[5]

318 Or 621> Before the 1989 amendments quoted above, the term "independent contractor" was neither used nor defined in the workers' compensation statutes. However, a substantial body of judicially created law had developed, interpreting the definition of "worker" currently found in ORS 656.005(28) and recognizing that persons who met certain judicially created tests for determining whether they were "independent contractors" were not "workers" covered by the workers' compensation law. "Independent contractor" and "worker" were mutually exclusive terms for purposes of determining workers' compensation coverage. In *Woody v. Waibel*, 276 Or 189, 192, 554 P2d 492 (1976), this court stated:

"The Workmen's Compensation Act, which is applicable only to the relationship of master and servant, is predicated upon the assumption that it is possible in every case for the courts to distinguish between a servant and an independent contractor."

See also Landberg v. State Industrial Acc. Com., 107 Or 498, 501-02, 215 P 594 (1923) (right to recovery under workers' compensation law was dependent on establishing that plaintiff was a "workman" and not an "independent contractor").

In *Woody v. Waibel, supra*, this court quoted the definition of "workman" from ORS 656.005(28), which included the phrase "subject to the direction and control of an employer," and noted:

"[I]t is clear that by express provisions of the statute [that] control is an essential ingredient in the test for determining who is a servant within the meaning of the Workmen's Compensation Act." 276 Or at 196 (footnote omitted).

318 Or 622> The test for determining "control" in the workers' compensation context "is based not on the actual exercise of control by the employer, but on the right to control." *Great American Ins. v. General Ins.*, 257 Or 62, 66, 475 P2d 415 (1970) (citing cases). Factors considered by the courts in determining whether a "right to control" establishes an employment relationship have included, for example: whether the employer retains the right to control the details of the method of performance, *id.* at 68; the extent of the employer's control over work schedules, *Woody v. Waibel, supra*, 276 Or at 192 n 2; and whether the employer has power to discharge the person without liability for breach of contract, *Harris v. State Ind. Acc. Comm.*, 191 Or 254, 269, 230 P2d 175 (1951). Payment of wages is also a factor, *see Whitlock v. State Ind. Acc. Com.*, 233 Or 166, 170, 377 P2d 148 (1962), although it is not considered

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[5] Before the 1989 amendments, the statute quoted above in the text provided in part:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors.

"(8) Partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto.

"(9) A corporate officer who is also a director of the corporation and has a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officer. However, if the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS 215.203 and ORS chapter 308, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption." ORS 656.027 (1987).

decisive "where it is shown that the employee was actually under the control of another person during the progress of the work." *Harris v. State Ind. Acc. Comm., supra,* 191 Or at 271 (citing cases).[6]

This court's interpretation of ORS 656.005(28) became part of that statute. *See Stephens v. Bohlman,* 314 Or 344, 350 n 6, 838 P2d 600 (1992) (when court interprets a statute, that interpretation becomes a part of the statute as if written into it at the time of its enactment). ORS 656.005(28) has not been amended. Our task is to determine the effect of the 1989 addition of ORS 656.005(29) and ORS 670.600, and the 1989 amendments to ORS 656.027(7) to (9).

It is logical that a determination must be made under ORS 656.005(28) whether one is a "worker" before it can be determined if the *worker* is "nonsubject" under ORS 656.027. SAIF asserts, however, that the proper way to interpret those statutes together is first to determine if one meets all of the criteria for a statutory "independent contractor" under ORS 670.600. If the answer is "yes," then the **<318 Or 622/623>** inquiry is ended, and the statutory independent contractor is not subject to the workers' compensation law. If the answer is "no," *then* a determination must be made under ORS 656.005(28) as to whether one is a "worker." The later determination would incorporate the judicially developed "right to control" test, described above. If one is not a "worker," then one is not subject to the workers' compensation law. If one is a "worker," then a determination is made under ORS 656.027 as to whether one is a "nonsubject worker."

The problem with SAIF's proposed approach is that it overlooks the overall structure of the workers' compensation statutes. The statutory definition of independent contractor, in and of itself, does not alter the internal logic of the workers' compensation law, which requires, as an initial matter, a determination of whether one is a "worker." SAIF's approach fails to put the statutory definition found in ORS 670.600 into the context of the workers' compensation law.

S-W Floor proposes that, first, a determination be made as to whether one is a "worker" under ORS 656.005(28), using the judicially developed "right to control" test. If one is a "worker" under ORS 656.005(28), then a determination is made as to whether one is a "nonsubject worker" under ORS 656.027. Only if there is an issue about whether one is a "nonsubject worker" under the provisions of ORS 656.027(7), (8), or (9) does a determination need to be made as to whether one is a statutory "independent contractor" as defined in ORS 670.600. We are satisfied that that is a logical progression through the statutes.

There is a further interpretive issue to be resolved, however. ORS 656.005(28) defines a "worker" as a person who is "subject to the *direction and control* of an employer," whereas ORS 670.600 provides that an "independent contractor" "is free from *direction and control* over the means and manner of providing the labor or services, subject only to the right of the person for whom the labor or services are provided to specify the desired results." (Emphasis added.) If "direction and control" means the same thing in both statutes, then all statutory independent contractors, who by definition are not subject to "direction and control" pursuant to ORS 670.600(1), cannot be "workers" under ORS **<318 Or 623/624>** 656.005(28) because of the lack of "direction and control." This brings us to a dilemma: if statutory independent contractors can never be "workers" for purposes of workers' compensation laws in the first place, then why did the legislature refer to statutory independent contractors in the "nonsubject worker" statute?

S-W Floor posits (and DIF and the Court of Appeals agreed in this case) that the dilemma can be avoided by concluding that "direction and control" do not mean the same thing in both ORS 670.600(1) and ORS 656.005(28). *See, e.g., Enertrol Power Monitoring Corp. v. State of Oregon,* 314 Or 78, 84, 836 P2d 123 (1992) (use of a term in one portion of the Oregon Revised Statutes does not necessarily control the meaning of the same term in another portion of the statutes). S-W Floor argues that the "direction and control" provision in ORS 656.005(28) still incorporates the judicially created "right to control" test to

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[6] Where the relationship between the parties cannot be established by the "right to control" test, it is permissible to turn to the judicially created "nature of the work" test to determine if an employment relationship exists. *See Woody v. Waibel,* 276 Or 189, 197-98, 554 P2d 492 (1976) (so stating). Although DIF based part of its decision in the present case on the "nature of the work" of the carpet installers, that part of the decision related only to the portion of the audit period before the 1989 amendments went into effect and is not at issue before this court. Therefore, we do not discuss the "nature of the work" test.

make the initial determination of who is a "worker," but that a different test, an "actual control" test, should determine whether one is "free from direction and control" for purposes of ORS 670.600. Under S-W Floor's proposed interpretation, one might be a "worker" subject to direction and control (right to control) pursuant to ORS 656.005(28), but still qualify as a nonsubject worker under 656.027(7), (8), or (9) as an independent contractor who is free from direction and control (actual control). For the reasons that follow, we reject S-W Floor's proposed interpretation.

Although that proposed solution would give meaning to each of the relevant statutes, we are unable to find textual or contextual support for the proposition that "direction and control" has different meanings in ORS 670.600(1) and ORS 656.005(28). In both statutes, the term is used to describe a working relationship between two parties. The text and context of the statutes do not reveal whether the legislature intended the term to have different meanings in the two statutes. We therefore turn to the legislative history of the 1989 amendments for evidence of how the legislature intended these statutes to work together. *See PGE v. Bureau of Labor and Industries, supra,* 317 Or at 611-12 (describing methodology).

318 Or 625> The "independent contractor" statutes origin Joint Interim Committee on Labor, Subcommittee on Independent Contractors, which convened in 1988 to develop a statutory definition for "independent contractor" that would apply, not only to workers' compensation law, but also to unemployment compensation law, tax law, and construction contractor law. The subcommittee's draft of this legislation contained the provision that an independent contractor must be "free from direction and control over the means and manner of providing the labor or services." *See* Joint Interim Committee on Labor, Subcommittee on Independent Contractors, August 16, 1988, Exhibit A.

The Joint Interim Committee's draft of this legislation was introduced in 1989 as House Bill 2320. The substance of the entire bill can be summarized as follows:

The revenue code, ORS chapter 316, was changed to amend the definition of "wages" to exclude remuneration "[f]or services performed by an independent contractor, as that term is defined in section 1 of this 1989 Act."

The unemployment law, ORS chapter 657, was amended to provide:

> "Services performed by an individual for remuneration are deemed to be employment subject to this chapter unless and until it is shown to the satisfaction of the assistant director that:
>
> "(a) Such individual is an independent contractor, as that term is defined in [section 1 of this 1989 Act.]" ORS 657.040(1).[7]

ORS chapter 701, governing construction contractors, was amended to incorporate the new statutory definition of "independent contractor" into the definition of "builder." ORS 701.005(2)(d); Or Laws 1989, ch 762, 7.

318 Or 626> As noted above, the workers' compensation law was amended to incorporate the new independent contractor definition into the definition section of the workers' compensation law, *see* ORS 656.005(29), set forth above in text. Or Laws 1989, ch 762, 3. Section 4 of the 1989 act added the term "independent contractor" to portions of the "nonsubject worker" statute, ORS 656.027(7) to (9), set forth above in text.

HB 2320 was introduced into the House at the request of the Joint Interim Committee on Labor and referred to the House Committee on Labor. The House Committee on Labor, and later the Senate Committee on Labor, received testimony of representatives from the state agencies directly affected by

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[7] At the same time, numerous criteria for an exemption for "independently established businesses," such as having two or more contracts, having separate telephone services, having business cards, engaging in commercial advertising, and providing tools and equipment necessary for carrying out contracts, were eliminated from this section. ORS 657.040 (1987); Or Laws 1989, ch 762, 6. *Cf.* ORS 670.600(3), (8); Or Laws 1989, ch 732 1 (incorporating similar provisions into new statutory definition of independent contractor).

the new independent contractor provision. The first person to testify in favor of this bill before the committees in both the House and the Senate was Larry Young, manager for the compliance division of the Workers' Compensation Division of DIF, who had participated in the joint interim subcommittee that drafted the bill. In the House Committee on Labor, he was asked to explain the results of the interim committee's work. He offered the following response:

> "MR. YOUNG: The Workers' Compensation Division supports House Bill 2320A regarding independent contractors. The proposal in House Bill 2320 clarifies one of the most confusing areas of workers' compensation, not only for those of us working in the system, but also for Oregon employers. Before expanding upon the reasons we support this bill, it may be beneficial to review the statutory coverage requirements and the impact they have on the system.
>
> "By statute (ORS 656.017) all employers who 'subject workers' are required to provide workers' compensation insurance for those workers. All workers are 'subject workers' except for those workers deemed as non-subject under ORS 656.027. * * * Simply put, employers are not required to provide coverage for any workers listed in 656.027.
>
> "* * * * *
>
> "You will note in ORS 656.027 that 'independent contractors' are not listed, so they are subject workers unless they are 'sole proprietors,' 'partners,' 'corporate officers' or any of the other employments listed there. To determine **<318 Or 626/627>** when they are not subject requires the use of case law definitions. This is confusing and contributes to misunderstanding and abuse. There are situations where, in order to avoid premium payments, employers claim persons working for them are independent contractors. At the same time, there are employers who do not have coverage because they believe they only have independent contractors under contract when they actually have employees. There are also many employers who are covered but do not pay premiums on many jobs they believe are being done by independent contractors, only to end up paying unexpected premium as a result of a premium audit.
>
> "House Bill 2320A provides a clear definition of 'independent contractor' and the conditions under which they are or are not subject to the Workers' Compensation Law. This will greatly assist investigators and auditors, as well as employers, in determining when individuals or business entities are in compliance with or [in] violation of the law. Also, when such determinations are appealed, those reviewing the issue will be assisted by having a specific statutory definition.
>
> "House Bill 2320A also makes the definition of 'independent contractor' apply to the laws of employment, revenue and Builder's Board as well as workers' compensation. This change will contribute greatly to eliminating confusion and unintentional violations by employers. As an example, since the Employment Division laws and our laws are not the same, on many occasions employers have not provided workers' compensation coverage because the worker was not subject to unemployment tax. With House Bill 2320A, if they are exempt under one, they'll be exempt under another. Also, with House Bill 2320A, if one of the other agencies determines noncompliance in this area, we should be able to issue our own order of noncompliance without conducting another investigation." House Committee on Labor, January 25, 1989, Tape 13, Side A; House Committee on Labor, January 25, 1989, Exhibit C.[8]

Later during the same committee meeting, a representative questioned one of the witnesses who was testifying against the bill: "You're not objecting to the thrust of this legislation, which is to come up with a single scheme that **<318 Or 627/628>** would apply across the board in commerce?" House Committee on Labor, January 25, 1989, Tape 13, Side B.

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[8] The substance of this oral testimony, as well as the accompanying written testimony, was later presented to the Senate Committee on Labor. *See* Minutes, Senate Committee on Labor, June 7, 1989, at 4-5, and Exhibit B (so demonstrating).

That legislative history strongly suggests that the primary purpose of House Bill 2320 was to achieve uniformity in who qualifies as an independent contractor, so that one who is an independent contractor for purposes of one of the four laws cited above would also be an independent contractor for purposes of the other three laws.

The legislative history also answers the question whether the "direction and control" test incorporated into the new statutory definition is the same as, or different from, the "direction and control" test (the judicially created "right to control" test) under ORS 656.005(28). The Joint Interim Committee on Labor, Subcommittee on Independent Contractors, discussed the "direction and control" phrase in the new statutory definition:

> "SENATOR HOUCK: [Speaking to Fred Van Natta, a witness representing the State Homebuilders' Association] I'm curious of your reaction to [the provision containing the 'direction and control' language] because it's one of the cornerstones of, you know, the construction industry here, is the 'free from direction and control over the means,' and I don't quite understand your either endorsement or nonresistance to that. * * *
>
> "REPRESENTATIVE SHIPRACK: You know, *this is an old, old test again, a common law test*.
>
> "SENATOR HOUCK: Well, I know it is.
>
> "* * * * *
>
> "SENATOR HOUCK: Well, I guess my concern is to get Fred's reaction to it here. *This is not a new definition* or new issue. But it's certainly one that has been at the top of the list of a lot of people's minds to the care, custody, control issue.
>
> "MR. VAN NATTA: If I may, Mr. Chairman.
>
> "REPRESENTATIVE SHIPRACK: Go ahead, yes.
>
> "MR. VAN NATTA: I didn't quarrel with that in part because *it's a traditional language* that is really key to the issue and *it's historically been interpreted*.
>
> "* * * * *
>
> "SENATOR HOUCK: Okay, you know one of the reasons I wanted to have this discussion,
>
> **<318 Or 629>** "REPRESENTATIVE DWYER: For the record --
>
> "SENATOR HOUCK: *I wanted to put it on the record*. I'm not uncomfortable with the way the thing has gone. *I just don't want to, after we overhaul it, to have that issue be challenged here. As long as we all understand it that there is a traditional history behind this clause, I feel comfortable with it*. As long as this goes on the record, okay?" Joint Interim Committee on Labor, Subcommittee on Independent Contractors, August 16, 1988, Tape 1, Side B, Tape 2, Side B (emphasis added).

That discussion suggests that the subcommittee in which the phrase "direction and control" originated intended the body of judicially created law interpreting "direction and control" under ORS 656.005(28) to apply to the new definition of "independent contractor."

Further support for the conclusion that the same judicially created "direction and control" test was intended to be used in the new definition of independent contractor can be found in statements made by Mr. Young of DIF to the Senate Committee on Labor when that committee first considered HB 2320:

> "MR. YOUNG: Section 1 is the definition of an independent contractor, and it provides that, and I might say, Mr. Chairman, that *it basically uses the law definition of independent contractor that the courts have used throughout the years* for all the respective agencies -- definition of independent contractor. It provides that the individual/business entity must be *free from the direction and control* * * *." Senate Committee on Labor, June 7, 1989, Tape 171, Side A (emphasis added).

Other comments made during the Senate Committee on Labor's meetings also shed light on the legislative intent behind this bill:

"MR. DERBY: [Insurance agent, witness in opposition to bill] I'll make a general statement --. *I don't know anybody that is not under direction and control.* And this is brought up --

"* * * * *

"SENATOR HOUCK: *There's case law on that issue. That one has a lot of case law.* Care, custody, control.

"* * * * *

318 Or 630> "MR. DERBY: * * * If at any time a contractor accepts any direction or control, one time, he is no longer an independent contractor. * * * I think we've got a real can of worms.

"SENATOR KERANS: Well, I wouldn't torture the direction and control. I just wouldn't torture that too much.

"MR. DERBY: Okay, well, you asked me to address this.

"SENATOR KERANS: Yeah, that's just for your edification -- I hope, the chair hopes, it's something that's the least of the problems, because I think we all, *I think virtually everybody involved in the debate over independent contractor can look to what we know to be a pretty definitive body of case law and precedent about what supervision and control is.*" Senate Committee on Labor, June 7, 1989, Tape 174, Side A (emphasis added).

Those excerpts, as well as a great deal of discussion in committee not reproduced in this opinion, make it clear that the committee considered at length the "direction and control" issue and intended the case law interpreting that phrase as used in ORS 656.005(28) to apply to that phrase as used in the independent contractor definition found in ORS 670.600.

We therefore are unable to agree with S-W Floor's suggestion, and the Court of Appeals and DIF's conclusions, that the phrase "direction and control" in the ORS 670.600 definition refers to a different "actual control" test rather than the judicially created "right to control" test referred to by the legislators, which historically has been applied in conjunction with ORS 656.005(28). We therefore conclude that the same "direction and control" test appears in both ORS 656.005(28) and ORS 670.600.

Thus, we conclude that the statutes work together in the following manner. A determination first is made as to whether one is a "worker" before a determination is made as to whether that "worker" is a "nonsubject" worker pursuant to one of the exemptions of ORS 656.027. The initial determination of whether one is a "worker" under ORS 656.005(28) continues to incorporate the judicially created "right to control" test. One who is not a "worker" under that test is not subject to workers' compensation coverage, and the inquiry ends. The "nonsubject worker" provisions of ORS 656.027 never come into play. If the initial determination made under ORS 656.005(28) is that one *is* a worker because **<318 Or 630/631>** one is subject to direction and control under the judicially created "right to control" test, then one goes on to determine under ORS 656.027 whether the worker is "nonsubject" under one of the exceptions of that statute. We recognize that this approach makes the 1989 amendments to ORS 656.027(7) to (9) unnecessary because independent contractors will never be "nonsubject workers"; however, the alternative constructions would require this court either to insert into ORS 670.600 what has been omitted (a workers' compensation exclusion) or to omit what has been inserted (the judicially created right to control test found in ORS 656.005(28)).

In the present case, DIF used only ORS 670.600 in its determination of whether the installers were covered by the workers' compensation law after October 3, 1989, and interpreted the "direction and control" language in that statute as requiring an "actual control" rather than a "right to control" test. Because we have determined that its method of analysis was incorrect, we remand this case to DIF for reconsideration under the correct legal standard.

The decision of the Court of Appeals is affirmed in part and reversed in part. The case is remanded to the Department of Insurance and Finance for further proceedings.

Cite as 318 Or 632 (1994) April 14, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

BLACKLEDGE FURNITURE CO., INC., Respondent on Review,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and SAIF CORPORATION, Petitioner on Review.
(DIF 91-02-012; CA A76093; SC S40655)

In Banc
On review from the Court of Appeals.*
Argued and submitted January 6, 1994.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioner on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Peter L. Barnhisel, Corvallis, argued the cause for respondent on review.
VAN HOOMISSEN, J.
The decision of the Court of Appeals is reversed. The order of the Department of Insurance and Finance is affirmed.
*Judicial review from the Department of Insurance and Finance. 121 Or App 409, 854 P2d 942 (1993).

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318 Or 634> This case involves the statutory definition of independent contractor found in ORS 670.600[1] and its effect on statutory provisions for determining when a person is subject to the workers' compensation law, ORS chapter 656, and the judicially created tests relating to those provisions. Petitioner on review SAIF Corporation asks this court to reverse the Court of Appeals' decision in which it applied its conclusion from *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, 407, 854 P2d 944 (1993), that the statutory definition of independent contractor replaced the common law "right to control" and "nature of the work" tests for determining workers' compensation coverage. *Blackledge Furniture v. Natl. Council on Comp. Ins.*, 121 Or App 409, 854 P2d 942 (1993). For the reasons set forth in this court's opinion in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, ___ P2d ___ (1994), the decision of the Court of Appeals is reversed.

This case, like the *S-W Floor* case, arose in the context of a premium audit dispute between a company that uses the services of carpet installers and its insurer, SAIF Corporation. During the disputed period, July 1988 through June 1990, four carpet installers performed carpet installations for Blackledge Furniture Company, a home furnishing retailer. SAIF conducted an audit of Blackledge Furniture and included amounts paid to the four installers as part of the basis for the workers' compensation insurance premiums that it assessed.

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[1] ORS 670.600 provides in part:

"As used in various provisions of ORS chapters 316, 656, 657 and 701, an individual or business entity that performs labor or services for remuneration shall be considered to perform the labor or services as an 'independent contractor' if the standards of this section are met:

"(1) The individual or business entity providing the labor or services is free from direction and control over the means and manner of providing the labor or services, subject only to the right of the person for whom the labor or services are provided to specify the desired results[.]"

That statute was codified as ORS 701.025 at the time of the DIF order; it is currently codified as ORS 670.600, and will be referred to as such throughout this opinion. ORS 670.600(2) to (8) provide numerous other criteria that must be met for an individual or business entity to qualify as an independent contractor.

318 Or 635> Blackledge Furniture appealed to the Department of Insurance and Finance (DIF),[2] arguing that the installers were not workers subject to premium assessment. DIF based its final order in this case on the conclusions that it reached in the S-W Floor case, but found in this case that none of the carpet installers were "workers" based on the common law "nature of the work" test, *see Woody v. Waibel*, 276 Or 189, 196-97, 554 P2d 492 (1976). DIF therefore held that Blackledge Furniture was not subject to premium assessment based on amounts paid to the installers. However, unlike in *S-W Floor*, DIF did not apply a different analysis for the period after the statutory definition of "independent contractor," ORS 670.600, went into effect on October 3, 1989.

SAIF petitioned the Court of Appeals for judicial review of DIF's order, arguing that DIF erred in failing to apply the provisions of ORS 670.600 for the portion of the audit period beginning October 3, 1989. Relying on its decision in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra*, the Court of Appeals reversed the portion of DIF's order relating to the period October 3, 1989, through June 30, 1990. *Blackledge Furniture v. Natl. Council on Comp. Ins., supra*, 121 Or App at 412.

SAIF sought review in this court, offering a concession that the installers were not "workers" as that term is used in ORS 656.005(28) and the judicially created "right to control" and "nature of the work" tests. SAIF argued, therefore, that there is no reason to remand the case to DIF for a determination under ORS 670.600 as to whether they were "independent contractors."

Because it is undisputed that the installers were not "workers" under ORS 656.005(28), whether or not they are statutory "independent contractors" under ORS 670.600 is not determinative of their workers' compensation coverage. DIF did not err in making its determination under ORS 656.005(28). *See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra*, 318 Or at 630 (describing methodology).

The decision of the Court of Appeals is reversed. The order of the Department of Insurance and Finance is affirmed.

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[2] This department is now known as the Department of Consumer and Business Services but is referred to as DIF throughout this opinion.

Cite as 318 Or 636 (1994) April 14, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

LAKE OSWEGO HUNT, INC., Petitioner on Review,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and SAIF CORPORATION, Respondent on Review.

(DIF 90-11-001; CA A75468; SC S40457)

In Banc

On review from the Court of Appeals.*

Argued and submitted January 6, 1994.

Peter A. Ozanne, of Schwabe, Williamson & Wyatt, Portland, argued the cause for petitioner on review. With him on the petition was William H. Replogle, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent on review. With him on the response were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is reversed. The order of the Department of Insurance and Finance is affirmed.

*Judicial review from the Department of Insurance and Finance. 121 Or App 413, 854 P2d 947 (1993).

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318 Or 638> This case, like its companion cases *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, 407, 854 P2d 944 (1993), *aff'd in part, rev'd in part* 318 Or 614, ___ P2d ___ (1994), and *Blackledge Furniture v. Natl. Council on Comp. Ins.*, 121 Or App 409, 854 P2d 942 (1993), *rev'd* 318 Or 632, ___ P2d ___ (1994), involves a determination of how the statutory definition of "independent contractor" found in ORS 670.600 affects statutory provisions for determining when a person is subject to the

workers' compensation law, ORS chapter 656, and the judicially created tests relating to these provisions. Petitioner on review Lake Oswego Hunt, Inc., asks this court to reverse the Court of Appeals' decision reversing and remanding the portion of the Department of Insurance and Finance's (DIF)[1] order pertaining to the audit period from October 3, 1989, to March 1990. *Lake Oswego Hunt v. Natl. Council on Comp. Ins.*, 121 Or App 413, 415, 854 P2d 947 (1993). For the reasons that follow, the decision of the Court of Appeals is reversed and the order of the Department of Insurance and Finance is affirmed.

Petitioner Lake Oswego Hunt, Inc., operates a horseback riding club and offers riding lessons and horse training through the use of horse trainers. The trainers set their own fees, subject to petitioner's approval, and petitioner retains 20 percent of the fees for use of the facilities. SAIF Corporation charged petitioner premiums for amounts paid to these trainers during the period in question, and petitioner appealed the premiums to DIF.

DIF determined that the trainers were not "workers," based on the judicially created "right to control" test. DIF therefore concluded that the trainers were not subject to workers' compensation premium assessments. DIF did not apply a different analysis for the period after the statutory definition of "independent contractor," ORS 670.600, went into effect on October 3, 1989.

SAIF sought judicial review in the Court of Appeals, contending that DIF erred by failing to apply the statutory **<318 Or 638/639>** provisions for "independent contractor" found in ORS 670.600 for the portion of the audit period beginning October 3, 1989. Relying on its decision in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra,* 121 Or App at 402, the Court of Appeals reversed and remanded the portion of DIF's order relating to the period after the new definition went into effect. Lake Oswego Hunt v. Natl. Council on Comp. Ins., supra, 121 Or App at 415.

Lake Oswego Hunt, Inc., petitioned this court for review, arguing that the provisions of ORS 670.600 do not apply if a person is not a "worker" under ORS 656.005(28), as established under the traditional judicially created "right to control" and "nature of the work" tests. Petitioner argues that the Court of Appeals' decision in this case should be reversed and that DIF's order should be affirmed.

SAIF agrees with petitioner that if the trainers were not "workers" under ORS 656.005(28) under the judicially created tests, then there is no need to apply the provisions of ORS 670.600. SAIF, however, maintains that DIF and the Court of Appeals erred in determining that the trainers were not "workers" under the common law tests and asks this court to revisit that issue. We decline SAIF's invitation to expound on the judicially created "right to control" and "nature of the work" tests at this time. Like the Court of Appeals, *Lake Oswego Hunt v. Natl. Council on Comp. Ins., supra,* 121 Or App at 415, we perceive no error in the manner in which DIF applied the "right to control" test, nor do we believe that DIF erred in failing to apply a "nature of the work" test under these circumstances.

SAIF's suggested statutory construction regarding ORS 670.600 has been rejected by this court in *S-W Floor Cover Shop v. Natl. Council on Comp Ins., supra,* also decided this day. DIF correctly made its determination initially under ORS 656.005(28), without reference to ORS 670.600. *See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra,* 318 Or at 630 (describing methodology).

The decision of the Court of Appeals is reversed. The order of the Department of Insurance and Finance is affirmed.

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[1] This department is now known as the Department of Consumer and Business Services but is referred to as DIF throughout this opinion.

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Everett L. Weems, Claimant.

EVERETT L. **WEEMS** and METROPOLITAN DISPOSAL CORPORATION, an Oregon corporation, and EE EQUIPMENT, INC., an Oregon corporation, Petitioners on Review,
v.
AMERICAN INTERNATIONAL ADJUSTMENT COMPANY, and AIG RISK MANAGEMENT, INC., Respondents on Review.
(WCB TP-91026; CA A75753; SC S40726)

In Banc
On review from the Court of Appeals.*
Argued and submitted March 7, 1994.
Stephen R. Frank, of Tooze Shenker Duden Creamer Frank & Hutchison, Portland, argued the cause for petitioners on review. With him on the petitions were Arden E. Shenker and Michael J. Gentry.
Jerald P. Keene, of Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland, argued the cause for respondents on review.
GILLETTE, J.
The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.
Durham, J., filed a concurring opinion and in which Unis, J., joined.
*Judicial review from the Workers' Compensation Board. 123 Or App 83, 858 P2d 914 (1993).

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319 Or 142> In this workers' compensation case, petitioners asked the Workers' Compensation Board to approve, pursuant to ORS 656.587 (discussed post), a proposed settlement of a third-party action to which a paying agency had refused to give its approval. The Board disapproved the settlement. On judicial review, the Court of Appeals affirmed the Board's decision. *Weems v. American International Adjustment Co.*, 123 Or App 83, 858 P2d 914 (1993). We allowed review and now affirm the decision of the Court of Appeals.

Claimant sustained a compensable injury to his left leg while operating an industrial-sized garbage compactor on his employer's loading dock. Two clamping bolts came loose from the compactor while claimant was working with it. The compactor moved, crushing claimant's left leg; the leg had to be amputated at mid-thigh.

In addition to claiming and receiving compensation under the Workers' Compensation Law, ORS chapter 656, claimant commenced a negligence action against Metropolitan Disposal Corporation, the owner of the compactor, and EE Equipment, Inc., a company that serviced the compactor (collectively referred to as MDC).[1] Claimant's wife joined in the action, seeking damages for loss of consortium. Claimant asserted in his complaint that MDC knew or should have known that the bolt-clamping mechanism was inadequate or failing. MDC denied any negligence and asserted in response that claimant's injury was due to his own negligence.

Following settlement negotiations conducted before a circuit court judge, claimant and MDC agreed to settle his negligence claim for $250,000. At the same time, claimant's wife and MDC agreed to settle her loss of consortium claim for $330,000. The settlement then was tendered to the paying agencies for their approval. A "paying agency," in this context, is a self-insured employer or workers' compensation insurer paying benefits to the worker or beneficiaries with a **<319 Or 142/143>** third-party right of action. ORS 656.576.[2] In this case, the paying agencies were American International

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[1] Claimant also asserted a claim for products liability; that claim, however, was dismissed on statute of limitations grounds. That claim is not an issue in the present proceeding.

[2] For a general discussion of the third-party action provisions of the workers' compensation law, *see Toole v. EBI Companies*, 314 Or 102, 105-07, 838 P2d 60 (1992).

Adjustment Co. and AIG Risk Management (collectively referred to as AIAC). AIAC asserted its right, under ORS 656.587, to disapprove the settlement of claimant's negligence claim. That statute provides:

> "Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

ORS 656.580 provides that the paying agency has a lien against a claimant's third-party claim. Under that statute, the paying agency's lien "shall be preferred to all claims except the cost of recovering such damages." ORS 656.580(2). ORS 656.593 sets out the procedure for distributing the proceeds of any damages recovered in a third-party action. In the event that the claimant settles the action, "the paying agency is authorized to accept such a share of the proceeds as may be just and proper." ORS 656.593(3).

In the face of AIAC's disapproval of the proposed settlement, claimant and MDC asked the Workers' Compensation Board to approve the settlement under ORS 656.587 which, as noted, permits the Board to approve a claimant's settlement of a third-party action when the paying agency refuses to do so. In support of their petition to the Board, claimant and MDC submitted affidavits from MDC's counsel and from the circuit court judge who presided over the settlement negotiations. Both MDC's counsel and the judge opined that the proposed settlement was "reasonable." AIAC submitted opposing affidavits that opined that the proposed settlement was "so grotesquely out of proportion as to be far outside the maximum possible range of reasonableness." AIAC argued that the proposed settlement was, in fact, an attempt to allocate an excessive share of the settlement money to the wife's loss of consortium **<319 Or 143/144>** claim, thereby circumventing AIAC's lien on claimant's negligence claim. That lien totaled more than $200,000.

The Board disapproved the proposed settlement of $250,000 between claimant and MDC, concluding that the settlement appeared to be "grossly unreasonable." Claimant and MDC sought judicial review in the Court of Appeals, arguing that the Board's decision to disapprove the settlement was not supported by substantial evidence. Claimant and MDC also argued that the Board should have been bound by the settlement conference judge's opinion of the reasonableness of the settlement in the absence of "clear and convincing evidence" to the contrary. The Court of Appeals rejected the arguments of claimant and MDC and affirmed the decision of the Board.

The first issue on review that we consider is the role of a settlement judge's opinion of reasonableness in the Board's process of approving a settlement under ORS 656.587. As noted earlier, that statute provides:

> "Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

By its terms, ORS 656.587 grants to *the Board*, not to a settlement judge, the authority to approve a claimant's compromise of a third-party action when the paying agency refuses to give its approval.[3] The settlement judge has no authority to approve or disapprove a claimant's compromise of a third-party action. Under ORS 656.587, any such compromise is "void" unless approved by the paying agency or the Board.[4]

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[3] In contrast, the statutes in some jurisdictions, including Arkansas, Nebraska, and New York, provide for *court* approval of settlements in such cases. 2A Larson, The Law of Workmen's Compensation 14-448, 74.17(d) (1993).

[4] A judge's role in settlement negotiations between the parties to a civil case has its basis in the Uniform Trial Court Rules. UTCR 6.010(1)(g) provides that, "[i]n any civil proceeding the court may, in its discretion, direct the parties to appear before the court for a conference to consider: * * * the possible settlement of the case." UTCR 6.200 further authorizes each judicial district to adopt a supplementary local rule "providing for a uniform pretrial settlement conference procedure for use in all circuit court civil cases." Nothing in the Uniform Trial Court Rules contemplates the "approval" of a settlement by the settlement judge.

In this case, the circuit court judge who presided over settlement negotiations did not purport to "approve" the proposed settlement of claimant's third-party action. Rather, the judge provided an affidavit in support of claimant and MDC's petition to the Board seeking the Board's approval of the proposed settlement. In that affidavit, the judge stated her opinion that the settlement was "reasonable."

319 Or 145> Notwithstanding that unequivocal statutory grant of approval authority to the Board, claimant and MDC contend that this court should require the Board, as a matter of law, to defer to the opinion of the settlement judge regarding the reasonableness of a settlement, unless there is "clear and convincing evidence" to the contrary. For the reasons that follow, we decline to impose on the Board the rule of deference proposed by claimant and MDC.

Claimant and MDC argue that deference by the the opinion of the settlement judge is necessary to further the important public policy in favor of settlements. This court strongly encourages settlement of all kinds of legal disputes. However, in determining the proper scope of the Board's approval authority under ORS 656.587, we must look to the policy that inheres in the statutory grant of authority itself -- *i.e.*, the policy that the legislature sought to advance in granting approval authority to the Board -- rather than to any policies that may be advanced under the Uniform Trial Court Rules in institutionalizing the role of a settlement judge.

As the body generally charged with matters relating to the adjudication of claims under the Workers' Compensation Law, the Board plays a key role in the workers' compensation system. *SAIF v. Wright*, 312 Or 132, 137-38, 817 P2d 1317 (1991); *see also* ORS 656.726(2) (describing powers and duties of the Board). In that role, the Board is responsible for resolving many of the disputes that arise between claimants and paying agencies, whether insurers or self-insuring employers. The legislature's choice to grant to the Board approval authority over the settlement of third-party actions reflects the important role that the Board plays in the workers' compensation system as an arbiter of disputes between participants in the system. It necessarily follows that, in exercising its approval authority under ORS 656.587, the Board's responsibility is to consider the interests **<319 Or 145/146>** of claimants and paying agencies *as participants in the workers' compensation system.*

A circuit court judge involved in settlement negotiations between the parties to a civil action has a different role. There, the judge's role is to assist the parties as they evaluate the strengths and weaknesses of their respective cases and to attempt to facilitate a resolution acceptable to the parties. *See, e.g.*, LaMar, *Pre-Trial Settlement Conferences in Multnomah County*, 27 Willamette LJ 549, 553 (1991) (discussing the role of settlement judges). There is no statutory basis for requiring the Board to defer to an assessment of a proposed settlement made by a settlement judge in a case in which workers' compensation is involved. To require such deference, we would have to add words to ORS 656.587 that the legislature did not include when it committed approval authority to the Board. Consequently, we decline to adopt the rule of deference proposed by claimant and MDC. The Board is under no statutory obligation to give deferential consideration to an opinion expressed by a settlement judge regarding the reasonableness of a proposed settlement of a third-party action. Having rejected the rule of Board deference to the settlement judge proposed by claimant and MDC, we are left with the argument that the Board's decision to disapprove the proposed settlement was not supported by substantial evidence. See ORS 183.482(8)(c) (stating standard). As to this issue, claimant and MDC have not raised any question of legal error in the Board's application of its standard for approving settlements in third-party actions.[5] Rather, they argue **<319 Or 146/147>** merely that the record lacks substantial evidence to support the Board's decision to disapprove the settlement under that standard. The Court of Appeals already has addressed that question, *Weems v. American International Adjustment Co.*, *supra*, 123 Or App at 88, and we conclude that it would benefit neither bench nor bar for this court to revisit that substantial evidence issue in this case.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

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[5] As to the standard applied to the approval of a third-party settlement under ORS 656.587, the Board's order in this case states as follows:

> "Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is *reasonable*. * * *
>
> "* * * Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be *grossly unreasonable*."

(Emphasis supplied.)

DURHAM, J., concurring.

I concur with the majority's holding that the Board is not obligated to defer, or accord particular evidentiary weight, to the opinion of a settlement judge about the reasonableness of a settlement that the Board reviews under ORS 656.587. I find no statutory basis for such an obligation, and we cannot impose one on the basis of our own policy predilections.

In addition, I also concur in the rejection of claimant's substantial evidence argument. The amount of the consortium claim settlement, and the testimony of a lawyer regarding the relationship of a consortium claim's value to the value of the injured party's claim, support a rational finding that claimant's settlement was "grossly unreasonable."

Although I agree with the court's answer to the narrow questions that the petition for review presents, I write separately to explain more completely the basis for my concurrence. On the record and briefs before us, the court correctly avoids discussing the Board's failure to interpret ORS 656.587, to define its "grossly unreasonable" standard, and to explain rationally how its findings support its conclusion that claimant's settlement was grossly unreasonable. In the absence of some definition or explanation, the Board's "grossly unreasonable" standard begs the legal question: "Grossly unreasonable, as compared to what?" That question, in turn, requires an inquiry, which the majority does not undertake, as to whether the Board's standard directs and **<319 Or 147/148>** confines the Board's settlement review in a manner that is consistent with the general legislative policy underlying ORS 656.587. The order does not explain why the Board's authority, under ORS 656.587, to approve "[a]ny compromise by the worker * * * of any right of action against an employer or third party" permits it to disapprove claimant's settlement, which he negotiated, according to the settlement judge, in the context of a probable defense verdict, because his wife received more in settlement of her consortium claim. The order is all the more puzzling, because the Board said that, in reviewing this settlement under ORS 656.587, "this Board is without authority to consider such a [consortium] dispute."

The Board's failure to interpret the statute, or to explain rationally why its findings lead to its legal conclusion, may deprive the order of "substantial reason," *Springfield Education Assn. v. School Dist.*, 290 Or 217, 228, 621 P2d 547 (1980), and interfere with effective judicial review, *Ross v. Springfield School Dist. No. 19*, 294 Or 357, 370, 657 P2d 188 (1982). *See also Williams v. SAIF*, 310 Or 320, 329, 797 P2d 1036 (1990) (Unis, J., specially concurring) (stating reasons for the requirement of a rational explanation of the basis for an agency's order). The Board cannot evade its responsibilities to interpret statutes and rules and to explain rationally why its interpretation and findings lead to its legal conclusion, even though the Board's authority to approve settlements is quite broad. Compliance by the Board with those responsibilities is not an act of grace. *See Dickinson v. Davis*, 277 Or 665, 674, 561 P2d 1019 (1977) (describing the importance to judicial review of a proper agency order when the agency makes a discretionary decision pursuant to broad statutory authority). However, we cannot reach and decide those discrete legal issues under claims that the Board is required to defer to the opinion of the settlement judge, and that substantial evidence does not support the order.

Because the majority correctly resolves the issues stated in the petition, I concur.

Unis, J., joins in this concurring opinion.

A question regarding the consistency of those two statements of law arose during oral argument before this court. At no time before that, however, did claimant and MDC contend that the Board had failed to announce and apply a clear legal standard of approval to this case. Accordingly, claimant and MDC have not preserved for this court's review any issue regarding the arguable inconsistencies in the foregoing passages in the Board's order.

Cite as 127 Or App 49 (1994) March 23, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Buck E. Johnson, Claimant.

BUCK E. **JOHNSON**, Petitioner,
v.
CAPITOL CAR WASH and SAIF CORPORATION, Respondents.
(Agency No. 91-15665; CA A78763)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 10, 1993.
Max Rae argued the cause and filed the brief for petitioner.
Steven Cotton, 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.
ROSSMAN, P.J.
Affirmed.

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127 Or App 51> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in concluding that his benefits for permanent total disability should not be increased during the months when his attorney fees were being paid out of compensation. We agree with the Board's decision that no adjustment in benefits is authorized, and affirm.

While working for employer, claimant sustained a compensable injury for which he was awarded benefits for permanent total disability (PTD). The Board allowed claimant's attorney a fee of 25 percent, not to exceed $6,000, for his efforts in gaining the permanent total disability award. The fee was to be paid out of the award of compensation, pursuant to ORS 656.386(2). Claimant is receiving social security disability benefits that are less than his monthly benefits for PTD. The Department of Insurance and Finance (DIF) authorized SAIF to reduce the monthly PTD payment by the amount of claimant's monthly social security benefit, pursuant to ORS 656.209. It ordered that claimant's attorney fee of 25 percent be paid monthly from the remainder of PTD.

ORS 656.209(1) authorizes a reduction in PTD by the amount of federal social security disability benefits. It provides:

> "With the authorization of the department, the amount of any permanent total disability payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.
>
> "(a) If the benefits amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 exceeds the worker's federal disability benefit limitation determined pursuant to 42 USC 424a, the reduction in workers' compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount the worker would have received pursuant to ORS 656.001 to 656.794 had such reduction not been made.
>
> "(b) If the benefit amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 is less than the worker's federal disability benefit limitation determined pursuant to 42 USC 424(a), the reduction in workers' compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount of combined **<127 Or App 51/52>** benefits the worker receives below the federal benefit limitation."

The parties agree that claimant's "federal disability benefit limitation" is $827.20. Pursuant to ORS 656.209(1)(b), claimant's combined benefits from social security disability and PTD may not be less than that amount. Claimant's monthly benefit for PTD is $630.53. His monthly social security disability benefit is $620.60. DIF authorized SAIF to subtract $423.93 from claimant's permanent total disability benefits, leaving him with a monthly PTD benefit of $206.60, and combined benefits for PTD and social security of $827.20. DIF authorized claimant's attorney to receive 25 percent of $206.60 monthly as his fee. The Board affirmed DIF's calculation.

Claimant contends that the monthly deduction of attorney fees from claimant's monthly PTD amount of $206.60 has the effect of reducing claimant's "combined benefits" below the federal disability benefit limitation amount. He argues that his monthly benefits for PTD should be increased by the amount of his attorney fees, so that his net share of PTD after payment of attorney fees equals $206.60. Claimant is wrong. The amount that he pays his attorney pursuant to ORS 656.386(2) is from his monthly benefit, not in addition to it. His total benefit, including that amount that he must pay to his attorney, cannot fall below the federal benefit limitation. Authorizing claimant's attorney to receive 25 percent of $206.60 does not result in combined benefits below the federal limitation, because the amount of the attorney fee is included within the total benefits.

Claimant's calculation would make SAIF responsible for his attorney fees. There is no provision in ORS 656.209(1) for such an adjustment, and we reject it.[1] We conclude that the Board did not err in holding that claimant's compensation for PTD is not to be increased by the amount of his attorney fees.

Affirmed.

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[1] Federal provisions on which claimant relies relating to the consideration of attorney fees in the reduction of social security disability benefits by the amount of a worker's workers' compensation benefits are not applicable or helpful. *See* 20 CFR 404.408(d).

Cite as 127 Or App 153 (1994) March 30, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

REFORESTATION GENERAL CONTRACTORS, INC., Petitioner,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.

(90-03-030; CA A71621)

Judicial Review from Department of Insurance and Finance.

Argued and submitted May 26, 1993.

Gregory B. Snook and Allen, Kilmer, Yazbeck, Chenoweth & Voorhees, P.C., filed the briefs for petitioner.

David L. Runner, 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.

Peter A. Ozanne waived appearance for respondent National Council on Compensation Insurance.

Before Deits, Presiding Judge, and Richardson, Chief Judge,* and Riggs, Judge.

DEITS, P.J.

Reversed and remanded for reconsideration of the issues of reclassification and the allocation of Johnson's payroll; reversed as to premiums charged for Blehm Logging Co., Forest Development Co. and S. James Peterson Logging.

*Richardson, C.J., *vice* Durham, J.

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127 Or App 155> Petitioner seeks review of a Department of Insurance and Finance (DIF) amended final order requiring petitioner to pay additional workers' compensation premiums to its carrier, SAIF, for the audit period of July 1, 1987 to June 30, 1988. At issue are SAIF's reclassification of two employees for purposes of determining premium rates and the determination that three other individuals were subject workers.

During the disputed audit period, petitioner was a forest management consultant that provided reforestation and logging consultation services to landowners. For logging consultations, the type of work at issue in this audit, petitioner contracted with forest property owners to develop and administer forest management plans. Once the plans were approved, petitioner selected a logger to carry out the logging operations. Petitioner, the landowner and the logger then entered into a written contract to complete the described job. Petitioner's contractual obligations included performing certain forest management consultations, ensuring the logger's performance and receiving and disbursing funds.

During the period in dispute, petitioner employed Johnson, as vice-president, and Schuette. Much of Johnson's work was performed in an office. His duties included locating tree seedlings for purchase, approving expenditures and signing checks, and reviewing accounting results and contracts. Some of Johnson's work, however, was performed outside of the office, including travel to and from job sites, timber cruising, installing road and property boundaries, administering the logging contracts[1] and picking up log scaling tickets from loggers on the job sites. Schuette's office duties included accounting and record-keeping, performing timber cruise calculations, reviewing forest management appraisal data **<127 Or App 155/156>** and telephoning potential clients and subcontractors. His field duties were similar to those of Johnson.

In May, 1981, petitioner applied to SAIF for workers' compensation insurance coverage and for personal election coverage for Johnson, a corporate officer. In its application, petitioner described the nature of its business as "forest management services." In a telephone conversation with a representative of SAIF regarding Johnson's application for personal election coverage, Johnson described the business as a "service organization" that "develop[ed] contractor arrangement[s] [and did] consulting work." The SAIF representative's notes from that conversation specify that "subcontractors" did the actual reforestation work. Apparently, no mention was made of logging operations. In Johnson's application for coverage, he described himself as an "administrative and field representative for contacting clients and prospective clients[;] considerable vehicle travel and service sales."

To determine an appropriate workers' compensation premium rate to be paid by an insured, SAIF uses the business classifications and rates of the National Council on Compensation Insurance (NCCI), a licensed rating organization for workers' compensation insurance. NCCI's classifications and rates have been filed with and approved by DIF, to determine the premiums that SAIF charges individual businesses. See OAR 836-42-020; OAR 836-42-045. NCCI's classifications are included in its publication entitled *Scopes of Basic Manual Classifications* (Scopes Manual). NCCI also publishes *Basic Manual of Workers' Compensation and Employers Liability* (Basic Manual), which includes rules that guide NCCI's interpretation and application of the classifications. *Douglas Co. Farmer's v. Natl. Council on Com. Ins.*, 119 Or App 69, 849 P2d 1144 (1993).

Based on the information provided by petitioner, SAIF assigned Code 0124: Reforestation[2] and Code 8742: Outside Salespersons[3] to petitioner's business and Code 8742 **<127 Or App 156/157>** to Johnson for his personal election coverage. Petitioner did not challenge either of the classifications at that time. See ORS 737.505. From the inception of the policy, petitioner reported Schuette's and Johnson's payroll to SAIF under Code 8742.

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[1] As found by the director in the amended final order:

> "'Administering' a contract involves insuring that the [logger] performed work as described in the contract. If the [logger's] work was not performed within the terms of the contract, Schuette explained the situation to Petitioner's client. Schuette and the client discussed various responses, and the client told Schuette what response Schuette should make. Schuette relayed the response to the [logger] and continued to check the [logger's] work to insure performance."

[2] Petitioner never knew to whom Code 0124 applied, and that classification is not at issue in this case.

[3] In general, classifications are assigned according to the employer's business, not the various employments, occupations or operations within the business. *Mr. Lustre Car Care v. Nat'l Council on Comp. Ins.*, 99 Or App 654, 657, 783 P2d 1032 (1989). Code 8742 is one of the three standard exception classifications that exclude certain employees from the basic classification of their employer's business. It applies to outside salespersons who

> "are employees engaged in such duties away from the employer's premises. * * * In cases where outside salespersons * * * regularly perform duties in any degree of frequency at the premises of their employers, their total payroll would be assigned to the highest rated classification representing any part of their work."

During the period in dispute, Johnson filed two injury claims for separate injuries that he sustained while doing field work.[4] The information contained in the claims alerted SAIF to the possibility of changes in petitioner's business and provided the basis for an audit. As a result of the audit, SAIF transferred all payroll petitioner had reported in Code 8742 to Code 2702: Logging, and billed petitioner additional premiums for the revised classification.[5] SAIF also determined that three loggers, Blehm Logging Co. (Blehm), Forest Development Co. (Forest) and S. James Peterson Logging (Peterson), were subject workers and not independent contractors. As a result of the audit, SAIF billed petitioner for premiums owed for the loggers under Code 2702. Petitioner seeks judicial review of DIF's amended final order upholding the results of the premium audit.

Before reaching the merits of petitioner's challenges, we address SAIF's argument that petitioner has failed to exhaust its administrative remedies. SAIF contends that ORS 183.460 and OAR 137-03-060(2) require a party in a premium audit appeal to file exceptions to a hearings officer's proposed order. It argues that, by failing to do so, petitioner is precluded from seeking judicial review of those parts of the **<127 Or App 157/158>** final order that were incorporated, without modification, from the proposed order.

ORS 183.460 provides:[6]

> "Whenever in a contested case a majority of the officials of the agency who are to render the final order have not heard the case or considered the record, the order, if adverse to a party other than the agency itself, shall not be made until a proposed order, including findings of fact and conclusions of law, has been served upon the parties and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to the officials who are to render the decision."

OAR 137-03-060(2) provides, in part:[7]

> "When the agency serves a proposed order on the parties, the agency shall at the same time or at a later date notify the parties:
>
> "(a) When written exceptions must be filed to be considered by the agency; and
>
> "(b) When and in what form argument may be made to the officials who will render the final order."

The hearings officer issued a proposed order and complied with the required notice provisions. Petitioner did not file any exceptions to that order.

It is a general principle of administrative law that a party must exhaust available administrative remedies before seeking review of an agency's action. *Miller v. Schrunk*, 232 Or 383, 388, 375 P2d 823 (1962). A party who is dissatisfied with an agency's action may not bypass an available administrative review in favor of immediate access to the courts. See, *e.g.*, *Ebert v. Dept. of Rev.*, 307 Or 649, 771 P2d 1018 (1989). Once a party has initiated an administrative appeal, the party may not, through its own inaction, deny the agency an **<127 Or App 158/159>** opportunity to conduct a meaningful and informed review of the merits of the case. *Millenaux v. Dept. of Revenue*, 293 Or 536, 541, 651 P2d 724 (1982). As explained by the Supreme Court:

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[4] In December, 1987, Johnson injured his knee when he tripped while inspecting a logging operation. In February, 1988, he reinjured the knee while supervising a tree planting.

[5] During the period in dispute, the premium rate for Code 8742 was approximately $1.35 per $100 of payroll. The rate for Code 2702 averaged over $35 per $100 of payroll.

[6] DIF regulations, OAR 836-43-101 to OAR 836-43-270, provide for a contested case hearing for premium audit disputes. ORS 183.310(2)(a)(D). Accordingly, the proceedings are governed by ORS 183.310 to ORS 183.550.

[7] The rule applies to a premium audit appeal, pursuant to OAR 836-05-107:

> "Pursuant to the provisions of ORS 183.341, the Insurance Division adopts in its entirety the Attorney General's Model Rules of Procedure under the Administrative Procedures Act as published in the Oregon Attorney General's Administrative Law Manual dated March 1990."

> "A party does not exhaust his administrative remedies simply by stepping through the motions of the administrative process without affording the agency an opportunity to rule on the substance of the dispute." 293 Or at 541; *see also Jackson v. Dept of Rev.*, 298 Or 633, 695 P2d 923 (1985).

SAIF argues that exceptions to a proposed order, filed pursuant to ORS 183.460, give the director an opportunity to explain or correct alleged errors in the proposed order and, therefore, constitute an administrative remedy that an adversely affected party must always exhaust before seeking judicial review of the final order. We disagree. In a case such as this, where all of the issues raised by the petitioner on appeal were before the hearings officer, the petitioner's failure to restate its argument in the form of exceptions to a proposed order does not deny the agency an opportunity to conduct a meaningful and informed review of the merits of the case. The director has before him the entire record, including the petitioner's arguments. Because the records in these cases may be fairly extensive, filing exceptions to a proposed order could be highly beneficial to a petitioner as a means of highlighting those arguments. However, we do not believe that a petitioner's failure to do so denies the director a reasonable opportunity to make a fully informed decision on the substance of the dispute. Under the circumstances here, petitioner's failure to file objections to the hearings officer's proposed order was not a failure to exhaust administrative remedies.

Petitioner next argues that DIF's implicit conclusion that SAIF was authorized to assess retroactively additional premiums against petitioner is wrong as a matter of law. Petitioner contends that under the statute in effect at the time that the additional premiums were assessed, ORS 737.310(12) (*since amended* by Or Laws 1991, ch 768, 1), an insurer may not charge additional premiums for a policy year absent proof of one of three specific circumstances. That statute provided:

> **127 Or App 160>** "At the time a workers' compensation guaranty contract is issued, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are assigned and shall provide an adequate description of work activities in each classification. The insurer shall not bill an insured for reclassifying employees during the policy year unless:
>
> "(a) The insured knew or should have known that the employees were misclassified;
>
> "(b) The insured provided improper or inaccurate information concerning its operations; or
>
> "(c) The insured's operations changed after the date information on the employees is obtained from the insured."

SAIF argues that ORS 737.310(12) is not applicable here because the guaranty contract was issued to petitioner in 1981, several years before the statute was enacted or took effect. Or Laws 1987, ch 884, 52. SAIF contends that the written notice required by the statute is a prerequisite to application of the limitations on retroactive billing and that, because no notice was given here, the limitations do not apply.

In interpreting a statute, our task is to discern the intent of the legislature. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). The language of the statute itself does not indicate how its requirements should be applied to then-existing guaranty contracts. However, it seems unlikely that the legislature would have intended to apply the limitations on retroactive billing to contracts for which the written notice required by the statute had not been given.[8] Because written notice was neither required nor given **<127 Or App 160/161>** to petitioner here, we do not believe that the limitations on retroactive billing in effect at

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[8] In 1991, the legislature substantially amended ORS 737.310(12) and, in that revision process, dealt with this ambiguity. The amended version retained the notice requirement but omitted that part of the statute imposing limitations on retroactive billing. Instead, the legislature authorized DIF to promulgate rules governing retroactive billing. ORS 737.310(12) and (13); *see* OAR 836-43-190. Additionally, under Oregon Laws, chapter 768, section 10, insurers were required to give written notice to any insured who, because its contract was issued before the adoption of the 1988 version of ORS 737.310(12), did not receive the notice required under that earlier version of the statute:

the time petitioner was assessed additional premiums are applicable.[9]

Petitioner next argues that DIF erred in upholding SAIF's classification of Johnson and Schuette to Code 2702: Logging. The director concluded that petitioner did not prove that the classification was wrong. Petitioner argues that the classification contemplates active participation in logging operations and that, because its employees did not actively participate in logging operations, DIF erred in concluding that they could be classified under that Code.

The Scopes Manual provides that Code 2702 applies to "all types of logging and lumbering operations regardless of the size of timber being harvested." It applies to stump removals, thinning of timberland, tree and incidental brush removal in connection with housing developments, transportation by employees of logs to the mill, and construction and maintenance of logging roads. DIF's order quotes pertinent parts of the Code:

> "[Code 2702]: '[i]ncludes transportation of logs to mill; construction, operation, maintenance or extension of logging railroads. Must be used for independent contractors engaged in hauling logs in conjunction with logging and lumbering operations.'" (Quoting Basic Manual, Oregon Special Pages).

In a letter to petitioner explaining the final results of the audit, SAIF's senior audit analyst said that Code 2702 applies **<127 Or App 161/162>** to employees involved in "direct labor, supervision and driving engaged in all types of logging operations."

The director found that, among other duties, Johnson inspected tree plantings, examined planted areas, and picked up log scaling tickets from loggers on the job site during logging operations. Schuette's duties were found to include such things as administering tree cutting contracts and tree management areas and picking up log scaling tickets from loggers on the job site during logging operations. The director then concluded:

> "Johnson filed claims for injury occurring when he was actively on a reforestation and a logging job site. Johnson and Schuette were regularly on the job site when logging operations were in progress. *Therefore*, Johnson and Schuette performed duties correctly classified by SCOPES Code 2702." (Emphasis supplied.)

An agency is obligated to fully explain how its findings of fact lead to the decision that it makes. *Furnish v. Montavilla Lumber Co.*, 124 Or App 622, 863 P2d 524 (1993). The problem here is that DIF fails to explain why the factual findings lead to the conclusion that the duties performed by the employees were properly classified as "logging." *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). The language of the Scopes Manual, the Oregon Special Pages of the Basic Manual and SAIF's analyst's description of the classification suggest that Code 2702 applies only to individuals actively engaged in logging operations. DIF found that the employees were, at times, on the job site during logging operations, but it did not find that they were actively participating in logging operations. If it can be done in a manner that is consistent with the applicable rules and statutes, DIF may be able to "interpret" active involvement to include presence on a job site while logging operations are in progress.

> "If an insurer of a workers' compensation insurance policy did not give an insured the written notice required under ORS 737.310(12) (1989 Edition) prior to the effective date of this Act [August 1, 1991] because the insurer's workers' compensation guaranty contract with respect to the insured was entered prior to January 1, 1988, the insurer must give the insured the notice required in this section. The notice must be in writing, must include the rating classifications to which the insured's employees are assigned and must provide an adequate description of work activities in each classification. The insurer must give the insured the notice at the first renewal of the workers' compensation insurance policy occurring on or after July 1, 1992."

The effect of these legislative changes is that, eventually, no insured party will be retroactively billed for reclassifications pursuant to OAR 836-43-190 without having first been fully informed about its rating classifications.

[9] Our conclusion is consistent with *Duron v. NCCI*, 111 Or App 571, 826 P2d 107, *mod* 113 Or App 445, 833 P2d 1289, *rev den* 314 Or 391 (1992). Although the applicability of ORS 737.310(12) was at issue in that case, the specific argument presented here was neither raised nor decided there.

O'Leary v. Valley View Cutting, 107 Or App 103, 106, 810 P2d 1324 (1991). However, DIF must articulate that conclusion and provide a rational explanation for its holding that will facilitate meaningful judicial review. *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975).

SAIF argues that the reclassification is correct because it applies to the business as a whole. Again, it is **<127 Or App 162/163>** unclear how DIF's findings could lead to the conclusion that petitioner's business was logging. The director found that "[p]etitioner is a forest management consultant which furnished reforestation and logging consultation services to landowners." If, on remand, that finding is to serve as a basis to conclude that the classification is correct, the agency must provide the rationale for its conclusion.

Petitioner next argues that, even if some of Johnson's payroll was subject to reclassification, the director erred in upholding SAIF's decision to allocate Johnson's entire payroll to the classification for the duties carrying the highest premium rate.[10] Because this issue may arise on reconsideration by DIF, we will address it here. ORS 737.310(10) requires the director to prescribe by rule the conditions under which an employer "is permitted" to divide payroll among classifications. Pursuant to that authority, OAR 836-42-060 provides, in part:

> "(1) When there is an interchange of labor the payroll of an individual employee shall be divided and allocated among the classification(s) assigned to the employer provided verifiable payroll records of the employer disclose a specific allocation for each such individual employee.
>
> "(2) When there is an interchange of labor without verifiable records, the entire payroll of employees who interchange shall be assigned to the classification representing any part of their work which carries the highest authorized premium rate."

"Interchange of labor" means

> "an employee or employees at different times perform duties described by two or more classifications *assigned to an employer* according to the classification system used by the insurer." OAR 836-42-055(4). (Emphasis supplied.)

Petitioner argues that because SAIF assigned to Johnson only one classification, Johnson could not have performed an "interchange of labor." Consequently, petitioner asserts, DIF erred in applying OAR 836-42-060(2) to assign Johnson's entire payroll to a subsequently assigned classification. We agree. Under the language of the pertinent **<127 Or App 163/164>** rules, unless more than one classification had been assigned to Johnson, there could be no interchange of labor. Without an interchange of labor, no issue arises as to whether the employee's payroll should be either divided among classifications or assigned in full to a higher authorized classification.

SAIF argues that even if DIF erred in applying the quoted rules, it correctly applied Rule IV-E-2 of the NCCI Basic Manual (Oregon Special Pages), which allows the division of payroll among classifications that have not been assigned to the employer. The rule quoted by DIF provides, in part:

> "When there is an interchange [between operations subject to more than one classification], the remuneration of an individual may be assigned to any such classifications *which may be properly assigned* to the employer * * * and original payroll records of the employer disclose a specific allocation for each individual employee." (Emphasis supplied.)

SAIF reads the Basic Manual rule to mean that an employee's payroll may be allocated to a classification that was not originally assigned to the employer. That is a plausible reading of the rule. It is, however, inconsistent with the language of the administrative rules adopted by DIF. OAR 836-42-050 to OAR 836-42-060. We understand that the Basic Manual rules were part of SAIF's rating system that was filed with and approved by DIF. However, it does not appear that DIF has adopted the Basic Manual as administrative rules under the APA. ORS 183.310 to ORS 183.550. Accordingly, to the extent that the administrative rules and the Basic Manual rules are inconsistent, the administrative rules must prevail.

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[10] Petitioner does not challenge the assignment of Schuette's entire payroll to a higher premium classification.

We conclude that Johnson did not qualify for permissible payroll division, as defined by the governing administrative rules and, therefore, DIF cannot rely on those rules to uphold SAIF's reassignment of Johnson's entire payroll to one classification. Our holding does not mean that it is impermissible to transfer the entire payroll to a higher rated classification if the director finds on remand that a Code other than 8742 covers all of Johnson's duties.

Petitioner also assigns error to the director's conclusion that Blehm, Forest and Peterson were employees for purposes of workers' compensation insurance premiums. **<127 Or App 164/165>** The question of employee or independent contractor status is one of law, if the basic facts are not in dispute. *Woody v. Waibel*, 276 Or 189, 192 n 3, 554 P2d 492 (1976). Where there is conflicting evidence about the facts of the relationship, we review DIF's factual findings for substantial evidence. ORS 183.472(8)(c).

During the audit period, petitioner entered into three contracts, each with a different landowner and a different logger. Although the contracts were tailored to the particular jobs, they contained similar provisions:

1. Each contract provided that the logger performed work under the contract as an independent contractor;

2. Each contract referred to the employees of the loggers;

3. Each contract was for performance of a particular job and specified a particular result;

4. Each contract included a contract completion date and specified that time was of the essence;

5. Each contract provided that petitioner would mark the logging boundaries or designate the timber to be cut;

6. Each contract contained a provision that the petitioner acted on behalf of the client in administration and supervision of the agreement;

7. Each contract contained a payment reservation clause whereby petitioner, on the client's behalf, could reserve logging payments until the logger fully complied with the terms of the contract. The reserved funds were to cover any damages sustained by the client from the logger's performance.

In the course of performing their contracts, Blehm and Forest each hired and paid truckers to transport the logs to the mill. Peterson entered into contracts with his sons to assist him with the job for petitioner. During the audit period, each of the loggers entered into contracts with other entities.

127 Or App 166> Petitioner first relies on *Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 812 P2d 25 (1991) to argue that each logger was a sole proprietor and, as such, ORS 656.027(7) (*since amended* by Or Laws 1989, ch 762, 4)[11] exempts them from the workers' compensation statutes, regardless of whether they qualified as independent contractors. That decision, however, was overruled in *Little Donkey Enterprises, Inc. v. SAIF*, 118 Or App 54, 57-58, 845 P2d 1298, *mod* 121 Or App 643, 856 P2d 323 (1993), where we held that while a sole proprietor is barred from workers' compensation coverage for acts performed in that capacity, he or she is not barred when functioning as an employee of another business. DIF's refusal to exempt the loggers on that basis was not error.

Petitioner next argues that DIF erroneously relied on the "relative nature of the work" test to conclude that the three loggers were employees. Under *former* ORS 656.005(27) (renumbered ORS 656.005(28) in 1990), a worker or subject employee is one who is "subject to the direction and control of

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[11] At the relevant time, ORS 656.027 provided, in part:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors."

an employer." Under ORS 656.005(13), an employer is one who has "the right to direct and control the services of any person." The principal factors to consider in applying the right to control test[12] are:

> "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989).

Where the evidence is insufficient to support a finding under the right to control test, the nature of the work test is a rational method for making a finding as to an individual's status.[13] *See Premsingh & Assoc. v. Natl. Council on Comp.* **<127 Or App 166/167>** *Ins.*, 111 Or App 624, 627, 826 P2d 120, *rev den* 313 Or 300 (1992). Here, DIF applied the right to control test to each of the three loggers and, in each case, concluded that the test was inconclusive. It then applied the relative nature of the work test and concluded that the three loggers were employees for the purposes of workers' compensation premium assessment.

In applying the right to control test, DIF first evaluated the record for direct evidence of control. It identified several facts indicating independent contractor status, including the parties' express intent, the payment reservation clauses and the provisions for the performance of specific jobs, the fact that the loggers worked for other logging companies during the period in dispute and that the loggers retained the right to hire assistants. The parties do not dispute those findings. DIF concluded, however, that the control factor was inconclusive because other evidence was indicative of employee status.

DIF determined that petitioner's specification of the contract completion time, marking of the land boundaries or the timber to be cut and supervision of the contracts are direct evidence of petitioner's right to control the loggers. Although substantial evidence supports the factual findings, we disagree with DIF's conclusion as a matter of law. Any independent contractor is subject to the control of the hiring party by virtue of the fact that the contractor is directed to accomplish a desired result. *Sodorback v. Townsend*, 57 Or App 366, 369, 644 P2d 640, *rev den* 293 Or 394 (1982). However, the right to control test refers to the right to control the manner and means of accomplishing the result, not the right to control the result itself. *Great American Ins. v. General Ins.*, 257 Or 62, 67, 475 P2d 415 (1970). As explained by Larson:

> "An owner, who wants to get work done without becoming an employer, is entitled to as much control of the details of **<127 Or App 168/169>** the work as is necessary to ensure that he gets the end result from the contractor that he bargained for." 1B Larson, *Workers' Compensation Law* 8-66, 44.21 (1991); *see Marcum v. SAIF*, 29 Or App 843, 846, 565 P2d 399 (1977).

Accordingly, a hiring party's control over the quality or the description of the work, as opposed to the person performing it, will not automatically convert an independent contractor relationship into one of employment. 1B Larson, *supra*, at 8-75, 44.21. Here, petitioner's specification of a completion date and marking of the physical boundaries for each job are part of the end result for which petitioner contracted

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[12] Because the facts of this case arose before October 1989, we do not consider the effects of the 1989 statutory amendment relating to independent contractors. *See* ORS 656.005(29) and ORS 701.025.

[13] The nature of the work test takes into account

> "the character of the claimant's work or business--how skilled it is, how much a separate calling or enterprise it is, to what extent it may be expected to carry its own accident burden and so on--and its relation to the employer's business, that is, how much it is a regular part of the employer's regular work, whether it is continuous or intermittent, and whether the duration is sufficient to amount to the hiring of continuous services as distinguished from contracting for the completion of a particular job." 1B Larson, *Workers' Compensation Law* 8-27, 43.52 (1991).

and are not necessarily indicative of employee status. Similarly, petitioner's right to supervise the agreements goes to the right to ensure that the ultimate goal of the contract is accomplished.[14]

The facts of this case are distinguishable from those in which the hiring party's control was found to extend beyond the details of the desired result. In *Great American Ins. v. General Ins., supra,* the Supreme Court found that the employer had the right to control all phases of the desired construction project, including the type of equipment and when and where it was to be used, as well as the details of the method of performance. 257 Or at 67-68. Similarly, in *Nichols v. Baggarley,* 79 Or App 505, 509, 719 P2d 914 (1986), we found an employment relationship to exist where the employer scheduled when the hired carpenter would work and told him what, where and how to perform his work. In contrast, petitioner here did not control when the loggers would begin performance or designate the hours they would work. Petitioner retained no control over the methods employed by the loggers or the manner in which the loggers performed their duties. Rather, the contracts specified only that the loggers use "appropriate equipment" and perform **<127 Or App 168/169>** the designated work in "accordance with good forestry practices." We conclude that DIF erred in holding that the record contained direct evidence of petitioner's right to control the means and methods of the loggers' performance.[15]

As to the second and third factors, the parties do not dispute that Blehm and Forest were paid on a flat bid basis and Peterson was paid by the thousand board feet. They agree that all three loggers furnished and repaired their own equipment at their own expense. DIF was correct in concluding that the method of payment and the furnishing of equipment are indicative of independent contractor status.

As to the final factor, the right to fire, petitioner offered no direct evidence on the issue. We reject petitioner's argument that the right to fire factor is incongruous with the existence of a contract. The written contract in *Woody v. Waibel, supra,* 276 Or at 192 n 2, for example, expressly provided that either party could terminate the agreement without liability. However, although we recognize that petitioner has the ultimate burden of proof as to the loggers' status, we find nothing in the record to suggest that petitioner retained an unqualified right to terminate the contracts absent bona fide reasons of dissatisfaction. *See Henn v. SAIF,* 60 Or App 587, 593, 654 P2d 1129, *rev den* 294 Or 536 (1983); 1B Larson, *supra,* at 8-191 to 8-192, 44.35(g). We conclude that this factor is indicative of independent contractor status.

Based on our evaluation of the above factors, we conclude as a matter of law that, under the right to control test, the three loggers performed as independent contractors. Because the right to control test is conclusive on the issue, it is unnecessary to apply the relative nature of the work test. *Woody v. Waibel, supra,* 276 Or at 189.

Reversed and remanded for reconsideration of the issues of reclassification and the allocation of Johnson's payroll; reversed as to premiums charged for Blehm Logging Co., Forest Development Co. and S. James Peterson Logging.

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[14] In its discussion of Forest's status, DIF found that "the contract stated that petitioner supervised [Forest's] performance." We find no evidence in the record to support that finding. The three contracts provided that petitioner was acting "on behalf of Owner in administration and supervision of the contract." DIF quoted this provision and explained what it meant, *see* note 1, *supra,* but thereafter referred to petitioner's supervision of the loggers' *performance.* Because DIF did not make any specific finding that petitioner's right to administer and supervise the contract included the right to supervise the manner and methods of the loggers' performance, we assume DIF's references to "supervision" are to petitioner's right to ensure that the work being performed was according to the terms of the contract.

[15] DIF also concluded that the loggers' failure to be certified by the Oregon Employment Division constituted direct evidence of petitioner's right to control. We are unable to find anything in the record to support this factual finding. However, even if we were to accept a finding that the loggers were not certified, we do not see how this constitutes direct evidence of petitioner's right to control the loggers.

Cite as 127 Or App 230 (1994) April 13, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronnie E. Taylor, Claimant.

RONNIE E. **TAYLOR**, Petitioner,
v.
MASONRY BUILDERS, INC., SAIF CORPORATION, SCHOUTEN & SEARS and EBI COMPANIES, Respondents.
(91-08984, 91-03910, 91-03909, 91-08983, 91-08982; CA A80088)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 2, 1994.
Michael A. Gilbertson argued the cause and filed the brief for petitioner.
Michael O. Whitty, Assistant Attorney General, argued the cause for respondents Masonry Builders, Inc., and SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Randy G. Rice argued the cause and filed the brief for respondents Schouten & Sears and EBI Companies.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Affirmed.

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127 Or App 232> Claimant seeks review of a Workers' Compensation Board order on reconsideration holding that SAIF Corporation never accepted claimant's claim and therefore is not required by ORS 656.262(6) to prove by clear and convincing evidence that claimant's injury is not compensable. We affirm.

Claimant first suffered a back injury in July, 1979, while employed by EBI's insured. He was awarded 25 percent unscheduled permanent partial disability for that injury. In 1990, the Board denied his request for back surgery on the ground that he had lied about the extent of his 1979 injuries.

Later in November, 1990, while working for SAIF's insured, claimant allegedly injured his back while dismantling a scaffold. He filed a claim in December, 1990. On March 26, 1991, SAIF sent claimant a letter captioned, "DISCLAIMER OF RESPONSIBILITY AND CLAIM DENIAL":

> "SAIF Corporation disclaims responsibility for your condition(s) diagnosed as low back strain superimposed on pre-existing degenerative changes, lumbar spine.
>
> "It is our contention that your condition may be the result of your employment with Schouten and Sears and this is an aggravation of your claim C-8106747-4 with E.B.I. company (Orion Group). We suggest you file an aggravation claim with them.
>
> "SAIF Corporation has not requested the appointment of a paying agent pursuant to ORS 656.307.
>
> "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 * * *."

On April 1, 1991, claimant requested a hearing "for an aggravation or a new injury depending upon how the medical evidence develops." He also requested that the Compliance Section of the Workers' Compensation Division issue an order designating a paying agent pursuant to ORS 656.307. That statute provides, in part:

> "(1) Where there is an issue regarding:
>
> "* * * * *

127 Or App 233> "(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."

On April 19, 1991, the Compliance Section sent notices to SAIF and EBI informing them of claimant's request that an order issue under ORS 656.307. The notice stated, in part:

"In order to make a decision and process the request to designate a paying agent, Compliance requires answers to the following questions:

"(1) Is claimant's condition work-related?

"(2) Is responsibility between insurers or employers the only issue?

"(3) What is the current status of the claim?

"(4) If a denial has been issued, what is its intent?"

Both insurers responded that claimant's condition was work related, that the only issue was responsibility, that the claim was in denied status, and that the intent of denial was to deny responsibility.

The hearing requested by claimant convened on June 27, 1991, at which time SAIF orally denied the compensability of claimant's claim. Following a lengthy discussion off the record, the hearing was postponed.

Also on June 27, 1991, but unknown to the parties at the time of the hearing, the Compliance Section issued the order under ORS 656.307, designating EBI as the paying agent and containing the statement, "Each insurer agrees responsibility is the only issue."

At the continued hearing on January 10, 1992, counsel for SAIF contended that he did not know that an order had been issued under ORS 656.307 until informed by claimant's counsel just before the hearing. He said:

"It's our position that [the order] was a mistake. At the last hearing I went on the record and said our position all along has been that compensability is at issue. If we did anything to **<127 Or App 233/234>** indicate that to the contrary, that was a mistake, and if I need to, I'll clarify that we still think compensability is at issue and I'll orally issue such a denial here today."

The SAIF claims adjustor who processed claimant's claim also testified that she had made a mistake when she responded to the Compliance Section's inquiry "[b]y saying that responsibility was the only issue when it was compensability and responsibility."

The referee held that SAIF's denial of compensability at the June 27, 1991, hearing was a "backup" denial and that, under ORS 656.262(6), the burden therefore shifted to SAIF to prove by clear and convincing evidence that its initial denial of responsibility only was an error. Further, the referee held that SAIF had satisfied that burden and had proven that claimant's claim was not compensable because it was fraudulent.

A divided Board affirmed the referee, but on different grounds. A plurality of the Board held that acquiescence to the issuance of an order under ORS 656.307 does not constitute an acceptance of a claim, that SAIF was not precluded from denying compensability, that SAIF did not have the burden of proof in the matter, and that claimant had failed to carry the burden in proving that his back injury was causally related to his work activities. In its order on reconsideration, the Board reaffirmed that "SAIF never accepted claimant's injury claim."

On review, claimant contends that the Board's order is contrary to ORS 656.262(6), which provides, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or 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 **<127 Or App 234/235>** the paying agent is not responsible for the claim." (Emphasis supplied.)

Claimant asks us to hold as a matter of law that, when an insurer acquiesces to the designation of a paying agent pursuant to an order under ORS 656.307, it has accepted the claim. Therefore, he argues, a subsequent denial of compensability is a "backup denial" under ORS 656.262(6) and shifts to the insurer the burden of proving by clear and convincing evidence that a claimant's injury is not compensable.

Whether a claim has been accepted is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454, 832 P2d 1271 (1992). We review findings for substantial evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). Substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding. ORS 183.482(8)(c).

Substantial evidence supports the Board's finding that SAIF never accepted claimant's claim. SAIF's March 26, 1991, letter was captioned in bold print, "DISCLAIMER OF RESPONSIBILITY AND CLAIM DENIAL." The phrase, "this is a denial of your claim for benefits," also appeared in bold print at the bottom of the letter. At the June 27, 1991, hearing, SAIF's counsel orally denied compensability, thus contending that the claim was denied on grounds of both compensability and responsibility. In response to the Compliance Section's inquiry about the status of the claim, both SAIF and EBI responded that it was denied. Even if we were to hold that SAIF is bound by its concession of compensability reflected in the order issued under ORS 656.307, that concession would not alter the fact that SAIF never accepted the claim. The claim was always in denied status, and therefore ORS 656.262(6) does not apply. *See Allen v. Bohemia, Inc.*, 125 Or App 205, 208, 864 P2d 1365 (1993). The Board did not err in holding that claimant had the burden to establish the compensability of his claim, and substantial evidence supports the Board's findings that claimant's injury is not causally related to his employment.

Affirmed.

Cite as 127 Or App 247 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Randel G. Jensen, Claimant.

RSG FOREST PRODUCTS, Petitioner,
v.
RANDEL G. **JENSEN**, Respondent.
(WCB 92-02227; CA A80028)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1993.
Jeffrey S. Love argued the cause for petitioner. With him on the brief were Scott P. Monfils and Lane Powell Spears Lubersky.
Gordon S. Gannicott argued the cause for respondent. With him on the brief was Hollander, Lebenbaum & Gannicott.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Affirmed.

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127 Or App 249> Employer seeks review of an order of the Workers' Compensation Board affirming the referee's award to claimant of interim compensation. We affirm.

Claimant began having severe wrist and hand problems while working for employer. Claimant's supervisor told him that he would like to avoid having claimant file a workers' compensation claim and placed claimant in a light duty job for a few days. Employer then transferred claimant to a position that involved less repetitive use of his hands than did his original job, but claimant's problems continued. Claimant did not file a claim or see a doctor, because he feared losing his job. In September, 1991, claimant suffered an unrelated injury while working. Employer required him to undergo a urinalysis, which tested positive for marijuana. Employer fired claimant, but contacted him one month later to see if he wanted to return to work. Claimant declined, because he was still experiencing hand and wrist problems. Claimant then worked several short-term jobs, but could not continue working because of those problems.

Claimant consulted a doctor, who found that claimant was disabled from regular work due to his compensable hand and wrist condition. The doctor released claimant to modified work. However, claimant's limited work skills and the restrictions placed upon him by the doctor effectively precluded claimant from finding modified work. Claimant filed this claim in November, 1991, and employer denied it. The Board affirmed the award to claimant of interim compensation from the date of the claim through the date of employer's denial of the claim and affirmed the award of attorney fees under ORS 656.382(2). Employer seeks review of the Board's order.

Employer contends that our decisions in *Safeway Stores v. Owsley*, 91 Or App 475, 756 P2d 48 (1988), and *Dawes v. Summers*, 118 Or 15, 845 P2d 1308 (1993), "are controlling and [require] reversal of the Board's order on Reconsideration," arguing that claimant is not entitled to interim compensation, because he did not leave work as a result of his injury. Claimant argues that those cases are inapposite, and that the Board correctly relied on *Nix v. SAIF*, **<127 Or App 249/250>** 80 Or App 656, 723 P2d 366 (1986), in affirming the award of interim compensation.

In order to qualify for interim compensation, a claimant must establish that he or she has left work or suffered a loss of earnings as a result of an injury. *Bono v. SAIF*, 298 Or 405, 410, 570 P2d 70 (1977); *Safeway Stores v. Owsley*, *supra*.

We agree with claimant that the analysis in *Nix v. SAIF*, *supra*, is instructive in this case. In *Nix*, a claimant suffered an injury while driving the employer's truck. The employer learned of the accident that day and fired the claimant. The claimant could not work for two weeks after the accident because of his injuries. However, he contended that he was entitled to interim compensation from the date of the accident to the date that SAIF accepted his claim. The Board found that the claimant was "away from work" for only two weeks as a result of his injuries. The Board awarded him interim compensation for that period, although claimant had been fired on the day of the accident. We affirmed, saying:

> "Claimant in this case was away from work after recovering from his injuries for reasons that were unrelated to his injury: He had been fired. Therefore, after claimant's two weeks of disability, he was not entitled to interim compensation." 80 Or App at 659.

Relying on *Bono v. SAIF, supra,* we agreed with the Board that the claimant was not entitled to interim compensation after he had recovered from the accident, because he was not "away from work" as a result of his injuries. After the claimant's recovery, any time loss or loss of earnings he suffered was unrelated to his injuries.

Nix stands for the proposition that, in deciding whether an award of interim compensation is appropriate, the question is whether an injured worker has suffered a loss of earnings because of an injury, not whether the worker has left a particular job as a result of that injury. *See Weyerhaeuser Co. v. Kepford,* 100 Or App 410, 441, 786 P2d 745, *rev den* 310 Or 71 (1990); *Noffsinger v. Yoncalla Timber Products,* 88 Or App 118, 744 P2d 295 (1987), *rev den* 305 Or 102 (1988). We conclude that, if a claimant is injured at work, but leaves that job for reasons unrelated to the injury, interim compensation may be appropriate. If a claimant is in the work **<127 Or App 250/251>** force, but has suffered a loss of earnings as a result of the injury, the claimant may be entitled to interim compensation.

Notwithstanding our decision in *Nix,* employer argues that *Safeway Stores v. Owsley, supra,* and *Dawes v. Summers, supra,* require us to reverse the Board. *Owsley* and *Dawes* involved the termination of temporary partial disability benefits on an accepted claim. In both cases, the workers returned to modified work and were fired for reasons unrelated to their injuries. We held that the claimants were not entitled to temporary partial disability benefits. In *Owsley,* our analysis focused on whether the claimant would have been entitled to *any* temporary disability benefits had she not been fired. Because the claimant was earning more at the time she was fired than she was earning at the time of her injury, we concluded that her earnings had not been diminished as a result of her injury, and that she was not entitled to temporary partial disability benefits. The fact that the employer fired the claimant for reasons unrelated to her injury was of marginal significance to our analysis. 91 Or App at 480. In *Dawes,* the claimant did not seek other work after being fired. We concluded that after being fired, she had not lost wages as a result of her compensable inury.

Here, employer's argument is predicated on its assertion that claimant returned to modified work after his injury and was then fired for reasons unrelated to his injury. Employer's version of the facts is not supported by the Bord's findings. The Board found that, after employer became aware of claimant's injury, employer asked him not to file a claim. Employer placed claimant on light duty work for a few days and then transferred him to a position where his problems persisted. Claimant was then fired for reasons unrelated to his injury. We conclude that the facts in this case are distinguishable from those in Owsley and Dawes, and that those cases do not apply.

Employer also argues that, if claimant was not precluded from receiving interim compensation after being fired, the "burden of proof is on claimant to establish what temporary disability benefits, if any, he would have been entitled to had he not been fired." Employer's argument rests on its assertion that "it made clear to claimant that it wanted him to return to light duty work by placing him on modified **<127 Or App 251/252>** employment after his injury and offering reemployment thirty days after he was discharged." Employer contends that, because claimant refused to return to work for employer, he was not entitled to interim compensation. Employer offered to resinstate claimant several weeks before claimant filed a claim. We agree with the Board that, because claimant was not working for employer when he filed the claim, any discussion of *potential* modified jobs with employer would be speculative.[1] At the time claimant filed this claim, he was in the work force and had made reasonable efforts to find employment. We agree with the Board that the work restrictions placed on claimant resulted in a loss of earnings.

Because claimant "left work" and suffered a loss of earnings related to his injury, the fact that employer fired claimant for reasons unrelated to his injury does not preclude him, in this case, from receiving interim compensation.

Employer's remaining arguments do not require discussion.

Affirmed.

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[1] There is no evidence in the record that employer offered claimant work of any kind after he filed the claim.

Cite as 127 Or App 253 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Nancy G. Brown, Claimant.

UNITED AIRLINES, INC., Petitioner,
v.
NANCY G. **BROWN**, Respondent.
(WCB 92-06488; CA A79445)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 23, 1993.
Jerald P. Keene argued the cause for petitioner. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C.
James S. Coon argued the cause for respondent. With him on the brief was Royce, Swanson, Thomas & Coon.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Affirmed.

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127 Or App 255> Employer seeks review of an order of the Workers' Compensation Board holding that employer could not discontinue claimant's temporary disability payments based on its denial of compensability. We affirm.

Claimant compensably injured her lower back. She also had degenerative disc disease in her lower spine. Employer accepted the lower back claim and began paying temporary disability. Several weeks later, employer issued a "denial of continuing compensability," and unilaterally stopped paying claimant temporary disability benefits, because it concluded that the preexisting disease was the major contributing cause of her disability. The Board found that employer's denial did not entitle it to discontinue temporary disability benefits on the claim. It also found that employer's action was unreasonable and assessed penalties against employer.

Employer's first assignment is that the Board erred in requiring it to continue paying temporary disability benefits after it issued a "procedurally valid compensability denial." Employer argues that ORS 656.005(7)(a)(B)[1] allowed it to deny the compensability of a previously accepted claim, because medical information indicated that claimant's preexisting disease was the major contributing cause of her disability. Employer contends that, after it denied the claim, ORS 656.262(2)[2] allowed it to discontinue claimant's temporary disability benefits. According to employer, that provision permits "insurers to defer payment of benefits on claims pending a worker's challenge of that denial and a hearing on the merits." Claimant argues that employer's denial did not **<127 Or App 255/256>** provide authority for employer to unilaterally stop paying temporary disability benefits.

We discussed whether an employer could unilaterally stop paying temporary disability benefits after denying the compensability of a claim in *Safstrom v. Riedel International*, 65 Or App 728, 697 P2d 341 (1983), *rev den* 297 Or 124 (1984). In *Safstrom*, the employer accepted claim and began paying temporary disability benefits. Later, the employer issued a partial denial, claiming that the claimant's time loss was unrelated to his injury. We determined that denying an accepted claim "does not terminate the

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[1] ORS 656.005(7)(a)(B) provides:

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

[2] ORS 656.262(2) provides:

"The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer."

employer's obligation to pay temporary disability benefits" and held that the employer's denial was procedurally improper, because it did not comply with ORS 656.268.[3] 65 Or App at 732. *See also Roller v. Weyerhaeuser*, 67 Or App 583, 679 P2d 341, *mod* 68 Or App 743, 683 P2d 554, *rev den* 297 Or 124 (1984).

Employer argues that the enactment of ORS 656.005(7)(a)(B) essentially reversed *Safstrom* and *Roller*, and gives an employer the procedural authority to deny and stop payment on an accepted claim, based on "changes in causation." It relies on the language in ORS 656.005(7)(a)(B), which provides that, if a **<127 Or App 256/257>** compensable injury combines with a preexisting disease, "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." That argument is without merit. ORS 656.005(7)(a)(B) provides a basis for determining a worker's substantive right to disability and medical benefits. *See SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993); *Tektronix, Inc. v. Nazari*, 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993). Nothing in the text or context of ORS 656.005(7)(a)(B) suggests that the legislature intended that provision to provide an employer with the procedural authority to deny an accepted claim. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). If an employer concludes that the compensable injury is no longer the major contributing cause of the disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268. Because we conclude that ORS 656.005(7)(a)(B) does not authorize the denial of an accepted claim, we need not discuss employer's arguments about ORS 656.262(2).

Since the 1990 amendments, we have continued to hold that, after an employer accepts a claim and in the absence of claim closure, termination of temporary disability benefits is procedurally proper *only* when one of the circumstances in ORS 656.268(3)[4] exists. *See, e.g., Sandoval v. Crystal Pine*, 118 Or App 640, 848 P2d 1224 (1993). Employer does not argue that any of those circumstances exist. Employer was not entitled unilaterally to terminate claimant's temporary disability benefits.

Employer next assigns error to the assessment of penalties against it for unreasonably terminating claimant's disability benefits. ORS 656.262(10). In light of ORS **<127 Or App 257/258>** 656.268(3), which provides the basis for termination of temporary disability benefits, we conclude that the Board did not err in imposing a penalty.

Affirmed.

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[3] At that time, ORS 656.268 provided, in part:

"(1) * * * Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary or if the worker is enrolled and actively engaged in an authorized program of vocational rehabilitation * * *.

"(2) When the injured worker's condition resulting from a disabling injury has become medically stationary, unless the injured worker is enrolled and actively engaged in an authorized program of vocational rehabilitation, the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and employer, if any, and request the claim be examined and further compensation, if any, be determined. * * * If 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 total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section.

"(3) When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the self-insured employer or the employer's insurer decides that the claim is nondisabling or is disabling but without permanent disability, the claim may be closed * * *."

ORS 656.268 was amended in 1987, 1990 and again in 1991. Or Laws 1987, ch 884, 11; Or Laws 1990, ch 2, 16; Or Laws 1991, ch 502, 1.

[4] ORS 656.268(3) now provides:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

"(b) The attending physician gives the worker a written release to return to regular employment; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Cite as 127 Or App 259 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Marianne L. Sheridan, Claimant.

MARIANNE L. **SHERIDAN**, Petitioner,
v.
JOHNSON CREEK MARKET and UNITED EMPLOYERS INSURANCE, Respondents.
(WCB 91-09220; CA A79201)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 23, 1993.
Donald M. Hooten argued the cause for petitioner. On the brief was Daniel J. DeNorch.
Joanne W. Mills argued the cause for respondents. With her on the brief was Schwabe, Williamson & Wyatt.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Reversed and remanded with instructions to reinstate order on reconsideration dated July 9, 1991, and for reconsideration of July 2, 1991, denial.

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127 Or App 261> Claimant seeks review of an order of the Workers' Compensation Board. We reverse.

Claimant filed a claim for a chipped bone in her elbow, which employer accepted. She received surgery to remove a loose particle in the elbow, but she continued to experience symptoms. On December 14, 1990, employer issued a notice of closure, finding her medically stationary on November 26, 1990, and awarding her temporary disability but no permanent disability. On June 7, 1991, claimant requested reconsideration of the notice of closure, claiming that employer had prematurely closed the claim, or in the alternative, that she was entitled to an award of permanent disability.

On July 2, 1991, employer issued a denial of compensability of and responsibility for the elbow condition after November 26, 1990, based on its conclusion that the industrial injury was not the major cause of any orthopedic or neurological condition after that date.

On July 9, 1991, the Appellate Review Unit (ARU) issued its order on reconsideration of the notice of closure. It rescinded the notice of closure, because it determined that the closure was premature. It also ordered employer to pay claimant's attorney an amount equal to ten percent of any additional compensation awarded, up to a maximum of $420. On July 11, 1991, claimant filed a request for hearing. On July 30, 1991, the ARU issued an order withdrawing the July 9 reconsideration order. It held that it had not had jurisdiction on July 9 to reconsider the December 14, 1990, notice of closure, because the claim was in denied status as a result of the July 2 denial. Claimant then sent a letter to the referee, adding an appeal from the July 30 withdrawal order as an additional issue at hearing.

The referee affirmed both the July 30 withdrawal order and employer's July 2 denial. The Board adopted the referee's findings. It concluded that the purported withdrawal of the July 9 order on reconsideration was incorrect, but found that that withdrawal was in fact an amendment of the July 9 order on reconsideration, which effectively affirmed the notice of closure. It then found, however, that **<127 Or App 261/262>** the July 9 order on reconsideration was invalid, because claimant challenged the impairment findings, and the director did not appoint a medical arbiter as required by ORS 656.268(7) and *Olga I. Soto*, 44 Van Natta 697 (1992).[1] It also adopted without discussion the referee's conclusions affirming the July 2 denial.

Claimant seeks review, raising three assignments of error. She first challenges the Board's findings that the July 9 order on reconsideration was invalid. Second, she asserts that the Board erred by not ruling that the July 9 order improperly limited claimant's attorney fees. Because our resolution of both of those assignments depends on whether the ARU had the authority to issue the July 30 withdrawal order, we address that issue first.

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[1] In *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 860 P2d 822 (1993), we held that an order on reconsideration, issued without a medical arbiter's report, is not invalid.

Claimant argues that the ARU did not have jurisdiction on July 30 to withdraw its July 9 order for two reasons. First, she asserts that her July 11 request for hearing challenged the July 9 order, and therefore jurisdiction over the July 9 order vested in the Hearings Division, depriving the ARU of jurisdiction to withdraw that order. In the alterative, she argues that, "absent the request for hearing, the insurer's Notice of Closure dated December 14, 1990 would have become final by operation of law," because the time for requesting a hearing on the reconsideration order had passed before the July 30 order was issued. *See* ORS 656.268(6)(b). Employer responds that claimant did not appeal the July 9 order on reconsideration, and therefore the ARU had continuing jurisdiction to withdraw it. Employer also argues that the 180 days for appeal had not run, because the time during which the notice of closure is on reconsideration is not included in the 180-day calculation, and the reconsideration was ongoing until the withdrawal order was issued on July 30.

Claimant's first argument fails, because she did not request a hearing regarding the July 9 order. The July 11 request for hearing included the dates of the July 2 denial and the July 9 reconsideration order. It listed the reasons for the **<127 Or App 262/263>** appeal as: "DENIAL DATE 7/2/91," "COMPENSABILITY," and "PENALTIES AND ATTORNEY FEES." The Board found that, "[o]n July 11, 1991, claimant filed a Request for Hearing raising, as issues, the July 2, 1991 denial, compensability, and penalties and attorney fees. * * * Insurer did not file a request for hearing to challenge that July 9, 1990 [*sic*] Order on Reconsideration." Neither the request for hearing nor the findings clearly state whether the request for hearing raised any issues relating to the July 9 order on reconsideration. The only challenge claimant made to that order relates to the limitation on the amount of fees to be paid to her attorney. Both the request for hearing and the Board's findings mention attorney fees, but it is not clear whether those references relate to penalties and attorney fees for the July 2 denial, or to the limitation on attorney fees in the July 9 order on reconsideration, or both. However, a portion of the referee's order that was adopted by the Board makes it clear that the Board found that the July 11 appeal related only to the July 2 denial, and not to the July 9 order on reconsideration. The referee said, in his discussion regarding whether the order on reconsideration should be affirmed:

> "Claimant argues the ARU was without authority to issue its July 30, 1990 [sic] order withdrawing its July 9, 1991 Order on Reconsideration. * * *
>
> "* * * * *
>
> "At the time of the ARU's July 30, 1991 order withdrawing the July 9, 1991 Order on Reconsideration, *neither party had filed a request for hearing raising, as an issue, the July 9, 1991 Order on Reconsideration.*" (Emphasis supplied.)

The Board adopted that portion of the referee's order. Claimant does not challenge the finding that she did not appeal the July 9 order on reconsideration. Accordingly, we conclude that there was no appeal from the July 9 order and jurisdiction over that order never vested in the Hearings Division.

That does not mean, as employer argues, that the ARU had continuing authority on July 30 to withdraw its July 9 order. As we said in *SAIF v. Fisher*, 100 Or App 288, 291, 785 P2d 1082 (1990):

> "In the absence of a statutory provision limiting its authority to do so, an agency has plenary authority to decide matters committed to it by the legislature. That authority **<127 Or App 263/264>** includes the authority to withdraw an order and to reconsider the decision embodied in the order."

One limitation on that authority is that it exists only until an order becomes final. 100 Or App at 291; *see Lyday v. Liberty Northwest Ins. Corp.*, 115 Or App 668, 839 P2d 756 (1992). In *SAIF v. Fisher, supra*, we held that ORS 656.295(8), which provides that an order of the Board is final unless a party seeks review within 30 days, provides a limitation on the Board's authority to withdraw or amend its orders. A challenge to a notice of closure begins with a request for reconsideration. ORS 656.268(4)(e). ORS 656.268(6)(b) provides that, after the claimant has obtained reconsideration of the closure:

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

Although ORS 656.268(6)(b) does not specifically provide that the reconsideration order becomes final after the 180-day period has passed, that is the natural consequence of the statute. Once 180 days have passed, as provided in ORS 656.268(6)(b), the reconsideration order is final, and the ARU no longer has authority to withdraw or amend it.[2]

Employer argues that the 180-day period had not passed, because the time between July 9 and July 30, during which the ARU was "completing its evaluation of [claimant's] request for reconsideration," is not counted as a part of the time limitation. It relies in part on OAR 436-30-050(3), which provides:

> "The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 **<127 Or App 264/265>** days from the mailing date of the Notice of Closure or Determination Order to request a hearing."

Employer fails to cite subsection (a) of that same rule, which provides that "[t]he 180-day time limit will be tolled upon receipt of the request for reconsideration until the reconsideration request is either withdrawn, dismissed or an Order on Reconsideration is issued." Here, the order on reconsideration was issued on July 9. The issuance of that order started the running of the time limitation again. There is no dispute that, if the time began to run when the order on reconsideration was issued and there was no request for hearing from that order, the 180-day period had expired before July 30. Because there was no appeal from the July 9 order, it became final before July 30 and could not be withdrawn or amended.

Because the ARU did not have authority to issue its July 30 order withdrawing its July 9 order, that order is a nullity. Thus, the July 9 order was not withdrawn and it remains in effect. That order holds that the notice of closure was premature. Accordingly, the Board erred in affirming the notice of closure.

Claimant's second assignment goes to the limitation on the amount of attorney fees awarded in the July 9 order. Because the July 9 order was never appealed and became final, we cannot review any issues relating to it.

Finally, claimant assigns error to the Board's order affirming employer's July 2 denial. She argues that the denial is an attempt by employer to limit its scope of acceptance. Employer argues that the denial was merely a denial of claimant's current condition, and not improper as a backup denial or as an attempt to limit the scope of acceptance.

Claimant asserts that employer accepted a claim for a "chipped bone" in the right elbow. The 801 form lists the nature of injury as "chipped bone." Employer argues that it accepted only the dislodging of a bone fragment that had already been chipped before claimant's fall at work. Therefore, it argues, once the fragment was removed, any continuing need for medical treatment was related to the preexisting chipped bone and could be denied.

127 Or App 266> Employer relies for the denial on ORS 656.005(7)(a)(B). The Board, in adopting the referee's discussion on this issue, held that this denial was not an invalid preclosure denial, because ORS 656.005(7)(a) now allows such denials. As we held in *United Airlines v. Brown*, 127 Or App 253, ___ P2d ___ (1994), ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim. The Board must reconsider its order regarding the denial in light of that decision.

Reversed and remanded with instructions to reinstate the order on reconsideration dated July 9, 1991, and for reconsideration of the July 2, 1991, denial.

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[2] OAR 436-30-008(1) provides, in part:

"[T]he Appellate Unit may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order. * * * The Appellate Unit will act within the remainder of the appeal period after the reconsideration order being changed or cancelled is mailed only if a hearing has not been requested."

Neither party relies on this rule in support of its argument, and we do not rely on it as the basis for our decision.

Cite as 127 Or App 267 (1994) April 20, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

THE STEEL YARD, INC., Petitioner,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(91-07-037; CA A79750)

Judicial Review from Department of Insurance and Finance.
Argued and submitted February 16, 1994.
Barbee B. Lyon argued the cause for petitioner. With him on the brief was Tonkon, Torp, Galen, Marmaduke & Booth.
Peter A. Ozanne argued the cause for respondents. With him on the brief was Schwabe, Williamson & Wyatt.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Reversed and remanded for reconsideration.

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127 Or App 269> Petitioner seeks review of an order of the Department of Insurance and Finance (DIF) that requires it to pay an additional workers' compensation premium. We reverse and remand.

Petitioner is an Oregon corporation that sells iron and steel to retail customers. Its president and sole shareholder, Waltuck, was formerly president and one of two shareholders of The Standard Steel Companies (Standard). The other shareholder was Waltuck's wife. Standard operated three steel "service centers." Standard filed for bankruptcy in 1986. Later, the Hong Kong and Shanghai Banking Corporation (bank) became Standard's lender. Waltuck personally guaranteed Standard's line of credit. In 1988, the bank notified him that it intended to accelerate Standard's loans. Standard defaulted. In April, 1989, the Waltucks and the bank negotiated a settlement that transferred all of Standard's assets to a new corporation called Steel Products, Inc. (SPI), later called Northwest Steel Products, Inc. (NWSPI),[1] in exchange for the bank's surrender of Waltuck's personal guaranty.

In October, 1989, petitioner commenced doing business. In June, 1990, an auditor for respondent National Council on Compensation Insurance (NCCI) performed a classification inspection of petitioner's business. After the inspection, NCCI learned that Waltuck had a prior ownership interest in Standard. After reviewing petitioner's ownership documents and the transfer agreement between Standard and SPI, NCCI changed petitioner's loss experience rating factor,[2] based on its determination that petitioner was a "continuation" of Standard, and that Standard's loss experience rating factor should apply to petitioner. Petitioner's workers' compensation insurer, respondent Liberty Northwest Insurance Corporation (Liberty), assessed an additional premium. Petitioner then appealed the premium assessment **<127 Or App 269/270>** to DIF. The director of DIF concluded that Liberty "correctly applied" the modified loss experience rating factor. Petitioner assigns error to the assessment of the additional premium.

Petitioner first argues that the director applied a rule that does not resolve whether Standard's loss experience rating factor should be "transferred" to petitioner. NCCI contends that the order is based on the applicable rule. The order refers to the NCCI Experience Rating Plan Manual, part three, rule B, in its discussion of whether petitioner should pay premiums based on the modified loss experience rating factor. That rule provides:

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[1] NWSPI filed bankruptcy and discontinued operations in November, 1989.

[2] A loss experience rating factor is based on a workplace's safety record. A new business has a loss experience rating factor of 1.00. A poor safety record may result in an increase in the rating factor, which, in turn, can increase the cost of workers' compensation insurance.

"B. OWNERSHIP CHANGES

"Changes in ownership interest may affect the continued use of an entity's experience in future experience ratings. Based on the rules of this section of the Plan, when a change occurs, a determination shall be made to exclude or retain an entity's experience.

"* * * * *

"1. Exclude Experience

"The experience for any entity undergoing a change shall be excluded from future experience ratings if the:

"a. entire ownership interest after the change had no ownership interest before the change.

"b. collective ownership of all those having an interest in an entity both before the change and after the change amounts to either:

"(1) less than 1/3 ownership before the change, or

"(2) less than 1/2 ownership after the change.

"EXCEPTION: When a change in ownership takes place among members of an immediate family, the experience for all entities shall be retained in future experience ratings of the risk. * * *

"* * * * *

"NOTE: Future experience ratings of a risk shall retain all experience up until the date of the change. This includes any part of its operations which may have been sold, discontinued, or self- insured.

127 Or App 271> "c. If the experience of a risk is to be excluded, the experience modification no longer applies as of the date of the change. An experience modification of 1.00 (unity) shall apply effective the date of the change, unless acquired by an entity with an existing experience modification.

"2. Retain Experience

"The experience of any entity undergoing a change shall be retained in future experience ratings if not excluded under B.1. For example, the experience of all entities involved in a merger or consolidation is retained." (Emphasis in original.)

After setting forth the rule, the order provides: "The NCCI rule[] * * * tie[s] the experience modification factor to the ownership of the business." However, the order offers no explanation why rule B applies to the facts in this case.

An agency must articulate a rational connection between the facts that it finds and the legal conclusions it draws from them. *Mt. Hood Community College v. Employment Div.*, 101 Or App 314, 318, 790 P2d 1164 (1990). As we said in *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975):

> "If there is to be any meaningful judicial scrutiny of the activities of an administrative agency--not for the purpose of substituting judicial judgment for administrative judgment but for the purpose of requiring the administrative agency to demonstrate that it has applied the criteria prescribed by statute and by its own regulations and has not acted arbitrarily or on an ad hoc basis--we must require that its order clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes."

Here, the order's ultimate finding of fact provides:

> "Petitioner failed to meet its burden of proof that neither Waltuck nor his wife maintained [an] ownership interest in SPI or NWSPI and, therefore, the petitioning firm.""

Even if substantial evidence supports that finding, we are unable to ascertain how rule B provides authority to impose a modified loss experience rating factor on petitioner.[3]

127 Or App 272> Rule B on its face applies to ownership changes in *existing* "entities"[4] and states the circumstances under which an entity's loss experience rating does not survive a change in ownership. In this case, the uncontradicted evidence is that petitioner is a new corporation that materially differs from Standard.[5] We find no language in rule B that addresses what loss experience rating factor should apply to a new business owned by a person who formerly owned a different business.[6] Even assuming, for the sake of argument, that Waltuck had an ownership interest in SPI and NWSPI, we cannot determine from the order how rule B provides authority to impose Standard's loss experience rating factor on petitioner. We conclude that DIF's order fails to provide substantial reasons for its determination that rule B applies to the facts in this case. The order articulates no other legal basis on which Liberty was entitled to impose a modified loss experience rating on petitioner.

Reversed and remanded for reconsideration.

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[3] Waltuck gave uncontradicted testimony that he had no ownership interest in SPI or its successor, NWSPI, and that he did not know the identity of the owner or owners of those companies. Waltuck also indicated in writing, on a form provided by Liberty, that he did not know who the owner or owners of SPI or NWSPI were.

[4] The record does not include any rule defining "entity."

[5] Petitioner operates at a different location than did Standard. Unlike petitioner, Standard provided services that added value to the steel it sold. Moreover, Standard and its successors did business on a larger scale than petitioner.

[6] NCCI also argues that rule B 2. is applicable. However, that argument is based on factual allegations that Waltuck and his wife "own 100% of the stock in Standard Steel," and have "simply continued the business of selling steel products that they owned through their holdings in Standard Steel." The *only* evidence in the record that Waltuck's ownership of Standard stock after the sale of all of its assets to SPI consist of (1) Waltuck's uncontradicted testimony that he and his wife "were divested of [the stock] or we divested ourselves of it or negotiated settlement or however you want to characterize what happened," and (2) Waltuck's statement in a letter to Liberty that he "previously held stock" in Standard. There is no evidence in the record that petitioner sells or sold any steel products, or utilizes in any way any other assets acquired from the Waltucks' holdings in Standard.

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