In the Matter of the Compensation of
PRESTON E. JONES, Claimant
WCB Case No. 91-07095
ORDER ON REMAND
Malagon, Moore, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Jones v. Quimby Trucking Co., 123 Or App 637 (1993), rev den 319 Or 36 (1994). The court has reversed and remanded our prior order, Preston E. Jones, 44 Van Natta 1670 (1992), which: (1) concluded that the SAIF Corporation's challenge to claimant's continuing palliative chiropractic care on "efficacy" grounds did not violate the terms of the parties' stipulated order; and (2) held that the Director has exclusive jurisdiction over disputes concerning palliative medical services. Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), petition for rev pending, the court has remanded for reconsideration.[1]

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks an order enforcing the September 20, 1988 Stipulation and Order ("agreement") by directing that SAIF pay for palliative chiropractic care of two treatments per month. The agreement provided, in part:

> "SAIF Corporation rescinds its denial and agrees to pay for palliative chiropractic care of two treatments per month pursuant to OAR 436-10-040(2)(a)." (Ex. 3).

On May 16, 1991, SAIF disapproved claimant's treating physician's (Dr. Flanagan's) request for palliative care because the evidence did not establish that claimant required palliative care to continue employment. (Ex. 4). Dr. Flanagan requested Medical Director approval, which was denied. (Ex. 5).

The Referee denied claimant's request for an enforcement order. The Referee concluded that under the agreement as amplified by the administrative rule, SAIF had the right to require evidence of the efficacy of treatment. The Referee also concluded that SAIF had used the proper procedure to evaluate the palliative treatment by seeking review by the Medical Director.

On review, we affirmed the Referee's order. Preston E. Jones, supra. We concluded that by incorporating OAR 436-10-040(2)(a), the agreement allowed SAIF to challenge claimant's continuing palliative chiropractic care on "efficacy" grounds. To the extent claimant was challenging the Medical Director's order, we rejected such a challenge on the ground that the Director has exclusive jurisdiction over disputes concerning palliative medical services.

On appeal, the court reversed and remanded for reconsideration in light of Jefferson v. Sam's Cafe, supra. In that case, the court held that ORS 656.327, which provides a procedure for Director review of medical services disputes, does not apply to disputes regarding proposed medical treatment. The court concluded that since ORS 656.327 does not apply to future medical treatment, the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment.

In accordance with the court's mandate, we proceed with our reconsideration. Claimant argues that the Board should decide the case on a contractual claim issue and contends that it is not necessary for us to consider the effect Jefferson v. Sam's Cafe, supra, has on this case because this is not a "palliative care case."[2] We understand claimant's argument to be that he is not claiming entitlement to

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[1] The petition for review for Jefferson v. Sam's Cafe, supra, has been held in abeyance pending the court's decision in Niccum v. Southcoast Lumber Co., 123 Or App 472 (1993), rev allowed 318 Or 381 (1994).

[2] Alternatively, claimant asks that we hold this case in abeyance until the Supreme Court issues its opinion in Hathaway v. Health Future Enterprises, Inc., supra, and decides whether to grant the petition for review in Jefferson v. Sam's Cafe, supra. We decline to do so. See Alfonso S. Alvarado, 43 Van Natta 1303 (1991) (Board declined to hold review in abeyance pending Supreme Court decision because to do so would be inconsistent with its role as a decision maker or in furthering the dispute resolution process).

proposed medical treatment, as in Jefferson v. Sam's Cafe, supra. Rather, he seeks enforcement of the September 20, 1988 stipulation.

SAIF contends that neither party in this case has argued that ORS 656.327(1)(a) (interpreted by the Jefferson court) applies to these facts. We agree with the parties that there is apparently no dispute in this case concerning proposed medical treatment, as in Jefferson v. Sam's Cafe, supra. The issue here involves enforcement of a settlement stipulation.

SAIF argues that we should affirm our prior order because the Director has exclusive jurisdiction over noncompensable palliative care disputes. See Hathaway v. Health Future Enterprises, 125 Or App 549 (1993), rev allowed 319 Or 80 (1994). We proceed to address the parties' arguments on remand.

Claimant originally sought an order enforcing the agreement by directing that SAIF pay for palliative chiropractic care of two treatments per month. To resolve this dispute, we must decide: (1) whether the agreement allowed SAIF to terminate chiropractic care under any circumstances; and (2) if so, whether SAIF had adequate grounds to terminate chiropractic treatment.

The threshold question is whether we have jurisdiction to consider either issue. The Board generally has jurisdiction over a dispute regarding enforcement of a stipulated agreement. Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). We have held that, when a dispute solely concerns the meaning and appropriate application of a Stipulated Order's terms, the Hearings Division has jurisdiction to enforce the stipulation. See Patrick E. Riley, 44 Van Natta 281 (1992) (stipulation did not refer to any statute or administrative rule). However, where the stipulation references statutes or administrative rules that involve the Director's jurisdiction, claimant cannot invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director. See B.D. Schlepp, 44 Van Natta 1637 (1992); Kevin A. Haines, 43 Van Natta 1041 (1991).

We find that we have jurisdiction to consider whether the terms of the agreement allowed SAIF to terminate claimant's chiropractic care. However, we adhere to the conclusion in our previous order that we do not have jurisdiction to decide whether SAIF had adequate grounds to terminate chiropractic treatment because resolution of that dispute involves the Director's jurisdiction.

We first address whether the agreement allowed SAIF to terminate claimant's chiropractic treatment. On remand, claimant argues that the best evidence of the settlement comes from his testimony that he gave up a monetary settlement because he believed he would be getting two treatments per month "forever." Claimant contends that the settlement is final and SAIF may not avoid its contractual obligations.

The terms of the parties' agreement are binding. Sharon L. Dominy, 44 Van Natta 872, 873, on recon 44 Van Natta 974 (1992). The agreement provided that SAIF "agrees to pay for palliative chiropractic care of two treatments per month pursuant to OAR 436-10-040(2)(a)." (Ex. 3). The parties clearly intended their agreement to be subject to former OAR 436-10-040(2)(a). Because the terms of the agreement are not ambiguous, it is not necessary to consider evidence outside the agreement in order to discern the parties' intent. Therefore, we do not consider evidence of claimant's intent.

We continue to adhere to our prior conclusion that, because the agreement incorporated former OAR 436-10-040(2)(a), SAIF may challenge claimant's continuing palliative chiropractic care on "efficacy" grounds. Former OAR 436-10-040(2)(a) (WCD Admin. Order 6-1988) provided, in part:

> "Frequency and extent of treatment shall not be more than the nature of the injury or the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment."

The current version of OAR 436-10-040(2) (WCD Admin. Order 13-1992) provides, in part:

> "Frequency and extent of treatment shall not be more than the nature of the injury and process of a recovery requires, and shall be in accordance with utilization and treatment standards as prescribed by the department, or pursuant to a MCO contract. Insurers have the right to require evidence of the efficacy of treatment."[3]

[3] We note that the current administrative rules include a separate rule concerning palliative care. See OAR 436-10-041.

Thus, under both versions of 436-10-040(2), an insurer may challenge a claimant's medical services on "efficacy" grounds. That is precisely what SAIF did in this case. SAIF issued a denial of chiropractic treatment because, inter alia, the evidence did not establish that claimant required palliative care to continue employment. (Ex. 4). We conclude that the reference to OAR 436-10-040(2)(a) in the agreement was intended to eliminate or restrict claimant's entitlement to palliative chiropractic care. Thus, the agreement allowed SAIF to challenge chiropractic care under certain circumstances.

The second issue is whether SAIF had adequate grounds to challenge chiropractic treatment. We adhere to our previous conclusion that the agreement incorporated former OAR 436-10-040(2)(a) and resolution of the parties' dispute requires interpretation and application of that administrative rule. See Kevin A. Haines, supra. In our previous order, we agreed with the Referee's refusal to address claimant's challenge to the Director's order denying authorization for palliative care, reasoning that the the Director has exclusive jurisdiction over disputes concerning palliative medical services. We continue to adhere to that conclusion.

In the parties' agreement, SAIF agreed to pay for "palliative chiropractic care of two treatments per month pursuant to OAR 436-10-040(2)(a)." Claimant does not argue that the treatment at issue is curative, rather than palliative. See Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993). In any event, to the extent that claimant attempts to raise that issue, we decline to address it because claimant did not raise this issue before the Referee. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In 1991, Dr. Flanagan requested Medical Director approval of his request that claimant receive chiropractic treatments. The Medical Director issued a Palliative Care Order, concluding that the requested palliative care was not appropriately related to claimant's 1986 injury and had not been shown to be necessary to enable claimant to continue current employment. (Ex. 5). The Palliative Care Order provided that either party could request administrative review pursuant to OAR 436-10-008(6). Claimant's attorney requested the Director to review the order (Ex.6), but the Director declined on the ground that only the attending physician or the insurer can request review by the Director. (Ex. 7). There is no evidence in the record that claimant further pursued his administrative remedies.

Under ORS 656.245(1)(b), palliative care is not generally compensable. Hathaway v. Health Future Enterprises, supra, 125 Or App at 553. Claimant does not argue that his palliative care meets the criteria in ORS 656.245(1)(b), i.e., provided to a permanently and totally disabled worker or necessary to monitor administration of prescription medication required to maintain the worker's medically stationary condition or to monitor the status of a prosthetic device. Therefore, the Hearings Division and this Board lack authority to directly review such a dispute. See Daniel K. Bevier, 46 Van Natta 41 (1994).

However, if claimant's attending physician believes that palliative care that would otherwise not be compensable is necessary to allow claimant's to continue current employment, the physician must request approval from the insurer, and, if the insurer does not grant the approval, the physician may request approval from the Director. ORS 656.245(1)(b). The Hathaway court held that the procedure provided in ORS 656.245(1)(b) is the exclusive procedure available for contesting an insurer's decision not to approve palliative care, and that is a matter within the exclusive jurisdiction of the Director. Hathaway, 125 Or App at 553.

In the present case, we rely on Hathaway v. Health Future Enterprises, supra, and adhere to our previous conclusion that we lack jurisdiction to resolve the issue of whether claimant's palliative chiropractic treatment was appropriate. Likewise, we continue to hold that we are without appellate authority to review the Medical Director's Palliative Care Order.

Finally, in remanding this matter, the court has instructed us to reconsider our decision in light of Jefferson v. Sam's Cafe, supra. As previously noted, neither party contends that this dispute pertains to a future treatment. Nevertheless, to the extent that this case involves future chiropractic treatment, we also do not have jurisdiction to resolve this challenge to claimant's palliative treatment.

Therefore, to the extent that this case involves future chiropractic treatment, it concerns future palliative treatment. In other words, whether this dispute pertains to an interpretation of the parties' stipulation involving disputes concerning current or future treatment, the treatments are palliative. As such, the procedure available for contesting an insurer's decision not to approve palliative care is a matter within the exclusive jurisdiction of the Director. See Hathaway, 125 Or App at 553.

Accordingly, on reconsideration of our prior order, we affirm the Referee's order dated September 13, 1991.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL J. VANPATTEN, Claimant
WCB Case No. 93-13778
ORDER OF DISMISSAL
Williams, et al., Defense Attorneys

Claimant has requested Board review of Referee McCullough's July 22, 1994 Order of Dismissal. Noting that his previous request for Board review (dated August 20, 1994) erroneously referred to the Referee's July 22, 1994 dismissal order in WCB Case No. 94-04822, claimant asks that we excuse his mistake and accept jurisdiction over this case. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

This case (WCB Case No. 93-13778) arises from claimant's November 18, 1993 hearing request contesting the insurer's November 12, 1993 partial denial of his L4-5 disc herniation. On February 8, 1994, claimant, through his then attorney of record, notified the Hearings Division that the parties had resolved their dispute pursuant to a Claim Disposition Agreement (CDA).

On April 18, 1994, claimant filed another hearing request. This request was designated as WCB Case No. 94-04822. In the request, claimant contested the insurer's March 31, 1994 "back-up" denial of claimant's back injury claim.

On July 15, 1994, the Board approved the parties' amended CDA. Pursuant to that agreement, the insurer agreed to withdraw its "back-up" denial and claimant agreed to withdraw his hearing request from that denial.

On July 22, 1994, the Referee issued an Order of Dismissal, dismissing claimant's hearing request in WCB Case No. 94-04822. That same day, the Referee issued a second Order of Dismissal, dismissing claimant's hearing request in WCB Case No. 93-13778.

On August 20, 1994, claimant mailed, by certified mail, his request for review of the Referee's order in "WCB Case No. 94-04822" to the Board. The request indicated that copies of the request had been mailed to the insurer's counsel and claimant's former counsel. Claimant's request did not refer to the Referee's separate dismissal order in WCB Case No. 93-13778.

On August 23, 1994, the Board mailed mailed its computer-generated letter to all parties acknowledging claimant's request for review in WCB Case No. 94-04822.

On September 14, 1994, the Board received a hand-written letter from claimant. Noting that he had "quoted the wrong case number on my review I requested to be reviewed," claimant asked that we "excuse [his] mistake" and review WCB Case No. 93-13778.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's July 22, 1994 order was August 21, 1994, a Sunday. Consequently, the final day to perfect an appeal from the Referee's order was Monday, August 22, 1994. Anita L. Clifton, 43 Van Natta 1921 (1991).

A request for Board review of a Referee's order need only state that the party requests review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to clearly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Here, claimant's August 20, 1994 request clearly and unmistakably sought Board review of the Referee's July 22, 1994 order. However, claimant's request just as clearly and unmistakably identified the Referee's order in WCB Case No. 94-04822 as the case in which Board review was sought. Claimant's request did not refer to the Referee's separate dismissal order in WCB Case No. 93-13778.[1]

Recognizing his oversight, claimant now asks that we excuse his mistake and treat his timely filed August 20, 1994 request for Board review of the Referee's order in WCB Case No. 94-04822 as his request for Board review of the Referee's order in WCB Case No. 93-13778. We acknowledge claimant's explanation. Nevertheless, we are without authority to waive a jurisdictional requirement. Specifically, in order for us to retain jurisdiction to consider the Referee's dismissal order in WCB Case No. 93-13778, claimant must have filed his request for Board review of that order within 30 days of its issuance. Inasmuch as it is undisputed that claimant did not request Board review of that particular order until September 14, 1994, we lack authority to consider claimant's appeal. Our appellate authority is limited to claimant's appeal of the Referee's separate dismissal order in WCB Case No. 94-04822.

In reaching this conclusion, we are not challenging claimant's statement that he erroneously referred to WCB Case No. 94-04822 (rather than WCB Case No. 93-13778) when he sought Board review of the Referee's July 22, 1994 order. We are also mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Moreover, we are not free to relax a jurisdictional requirement.

Based on the aforementioned reasoning, we are without authority to consider the issues raised by claimant's request. Accordingly, the request for Board review is dismissed. (Inasmuch as claimant has timely requested Board review of the Referee's order in WCB Case No. 94-04822, we shall proceed with our review of that case).

IT IS SO ORDERED.

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[1] Had the Referee dismissed claimant's hearing requests in both WCB Case Numbers in one separate order, claimant's request for Board review would likely not have been fatal. Since a party seeks review of a Referee's order, not a case number, the failure to cite one of two WCB Case Numbers in a "consolidated" Referee's order would not deprive the Board of appellate jurisdiction. See Maree Elliott, 45 Van Natta 408 (1993); Grover Johnson, 41 Van Natta 88 (1989). Here, the Referee issued separate dismissal orders dismissing claimant's hearing requests in each WCB Case Number. In light of such circumstances, claimant's request for Board review referring to only one specific WCB Case Number can only reasonably be interpreted as his intention to appeal the Referee's order in that particular case.

Board Member Gunn specially concurring.

I write for the pro se claimant who will probably not fully comprehend the technical reasons for what we are doing.

This claimant's mistake and ultimate misfortune is that he wrote down the wrong WCB Case number in requesting Board review. By doing so, the Referee's order which pertained to the case number that he wanted to appeal has become final because no party requested Board review of that particular order within 30 days of its issuance.

Had claimant not specified a particular case number, we would likely have considered claimant's initial letter as a request for review of both Referee's orders. However, by specifying a certain WCB Case number, he restricted our appellate review authority to the one and only Referee's order which pertained to that case. In other words, we can only apply his statutory rights of appeal to the one order he designated by his request for Board review.

Since the Referee's other dismissal order (the only one carrying the WCB Case number not listed in claimant's initial request for Board review) has not been appealed within 30 days of its issuance, it has become final by operation of law. Claimant's recent letter explains his mistake in referring to the wrong case number in his initial request for Board review. Unfortunately, because that "amendment" letter has been filed more than 30 days after the Referee's separate dismissal order in this case number, the letter cannot be used to cure an untimely request for Board review.

In conclusion, it may seem that claimant is being denied Board review in this case for a minor technical error. However, it is claimant's responsibility to timely appeal the Referee's order in accordance with the law. Likewise, it is my (sometimes unhappy) responsibility to apply those same legal requirements in dismissing requests for Board review.

In the Matter of the Compensation of
SANDRA Y. SANDERS, Claimant
WCB Case No. 93-03978
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Peterson's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a mental condition; and (2) declined to assess penalties for an allegedly unreasonable denial. In her brief, claimant contends that the Referee erred in admitting into evidence a report from an independent medical examiner. On review, the issues are evidence, compensability, and penalties. We affirm.

FINDINGS OF FACT

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

On July 9, 1992, claimant's husband informed her that their mobile home had sold. Claimant broke down and, later that night, she sought treatment at the Emergency Room at St. Mary Medical Center. She was diagnosed with depression and insomnia.

In July 1992, claimant treated twice with Dr. Ramirez, M.D., and once with Dr. Dunlop, psychiatrist.

About August 1992, claimant and her husband moved to Kansas to live with her husband's sister. While in Kansas, claimant treated with Dr. Heckmann, psychiatrist.

In October 1992, claimant and her husband moved to Gooding, Idaho. Claimant began treating with Dr. Ferguson, psychiatrist, and Ms. Mallea, social worker (MSW).

On June 23, 1993, Dr. Turco, psychiatrist, examined claimant on behalf of the employer. (Ex. 26).

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing and on review, claimant argues that Exhibit 26 should not be admitted into evidence on the ground that the author of that exhibit impermissibly commented on claimant's credibility. (Tr. 3). Exhibit 26 is a psychiatric examination report from Dr. Turco, a psychiatrist who examined claimant

on behalf of the employer. At hearing, the Referee admitted Exhibit 26, with the exception of the last paragraph on page 1, and took claimant's objection under advisement pending closing arguments. Following closing arguments, the Referee admitted Exhibit 26 into evidence in its entirety. On review, claimant argues that the Referee erred in admitting Exhibit 26.

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).

Although acknowledging that a referee is not bound by the rules of evidence, claimant argues that the prohibition in the criminal law area against witnesses, including psychotherapists, rendering opinions on the credibility of another witness should be extended to workers' compensation cases. We need not address this argument because we agree with the Referee that Dr. Turco did not comment on claimant's credibility.

Dr. Turco stated that "[t]he history presented by [claimant] appears to be deceptive. I mention this primarily because it is not consistent with what has been noted in the records particularly as regards the family history and the developmental experiences this woman has had." (Ex. 26-1, emphasis in original). The Referee found that these comments were directed at the history provided by claimant, and that Dr. Turco made no comment that claimant was not credible. (Ex. 5). We agree and find that the Referee did not abuse his discretion in receiving Exhibit 26 into evidence.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following supplementation.

After moving to Idaho, claimant treated with Dr. Ferguson, psychiatrist, and Ms. Mallea, social worker. Only Dr. Ferguson's and Ms. Mallea's opinions support the compensability of claimant's mental stress claim. However, like Dr. Ferguson, Ms. Mallea had an incorrect history that the discussions regarding a possible consolidation of the loan center began about March 1992. However, the bank did not decide to study the possibility of consolidating the loan center until April 21, 1992, and the staff, including claimant, was not notified about this possibility until April 28, 1992. Therefore, Ms. Mallea's causation opinions are unpersuasive for the same reasons that the Referee found Dr. Ferguson's causation opinions unpersuasive.

In addition to finding the medical opinions supporting claimant's case unpersuasive because they were based on inaccurate histories, the Referee also concluded that claimant's mental disorder was caused by claimant's anticipation of losing her job due to layoffs which would occur if the employer closed the loan center where she worked. The Referee further concluded that such layoffs were conditions generally inherent in every working situation. The Referee's conclusion is supported by our holding in Arthur Miller, 46 Van Natta 71 (1994). In Miller, we found that a claimant's mental disorder was not compensable because it was attributable to the anticipation of his unemployment.[1] We noted in Miller, that advance warnings of possible layoffs were suggestive of conditions which are generally inherent in every working situation.

Penalties

We adopt the Referee's reasoning and conclusions regarding the penalty issue.

ORDER

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

[1] Although a signatory to this order, Member Gunn directs the parties to his dissenting opinion in Arthur Miller, 46 Van Natta 71 (1994).

In the Matter of the Compensation of
KELLY O. SULLIVAN, Claimant
WCB Case No. 93-02652
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Black's order that upheld the insurer's denial of claimant's claim for aggravation. On review, the issues are jurisdiction and aggravation. We vacate the Referee's order and dismiss claimant's hearing request.

FINDINGS OF FACT

We adopt the Referee's findings of fact and findings of ultimate fact, except finding number one.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that its January 28, 1993 denial of claimant's claim for aggravation was a nullity because the Board issued its January 27, 1993 order reopening the claim under its own motion authority pursuant to ORS 656.278.

ORS 656.278(1)(a) confers exclusive jurisdiction on the Board for "aggravation" claims filed after the 5 year period, under ORS 656.273(4), has expired. However, the own motion order is not valid if claimant perfects an aggravation claim prior to the expiration of his aggravation rights. Linda Coiteux, 43 Van Natta 364, 367 (1991). If claimant timely perfected an aggravation claim, then the Board does not have own motion jurisdiction and its January 27, 1993 Own Motion Order authorizing the reopening of claimant's claim is not a valid final order and is without legal effect.

Therefore, to determine whether the Referee had jurisdiction, we must first determine whether claimant perfected an aggravation claim prior to the expiration of his aggravation rights on September 14, 1992. See Daniel C. Reddekopp, 46 Van Natta 1536 (1994). If claimant failed to timely perfect an aggravation claim, then the Referee was without jurisdiction and our January 1993 Own Motion Order was valid.

ORS 656.273(3) defines a claim for aggravation as: "[a] physician's report establishing the worsened condition by written medical evidence supported by objective findings." To constitute a claim for aggravation under the statute, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992). The report must also indicate a causal connection between claimant's "worsened" condition and the compensable injury. Carlson, supra; Michael L. Page, 42 Van Natta 1690, 1693 (1990).

Claimant contends that his change to lighter work in June or July 1992, supported by the objective medical findings of restricted range of motion and a L4-L5 disc defect constitute a claim for aggravation. In particular, claimant relies on Dr. Purtzer's August 6, 1992 and September 3, 1992 reports.

Dr. Purtzer saw claimant on August 6, 1992 and obtained a history that claimant has had low back and left leg pain since 1986. Back examination revealed 50 percent normal range of motion and tenderness in the lumbosacral region. Dr. Purtzer felt that claimant had low back and left leg pain of undetermined etiology. He recommended that claimant undergo lumbar myelogram and CT scan. Other than minimal lateral protrusion of the L4-5 disc to the left, the myelogram and CT scan were normal. Thereafter, on September 3, 1992, Dr. Purtzer recommended that claimant obtain a second opinion regarding the possibility of surgery.

We find that these reports do not contain all applicable elements of a prima facie aggravation claim. The decreased range of motion noted by Dr. Purtzer is an objective finding. However, Dr. Purtzer failed to indicate that claimant's compensable condition has worsened. See Emily P. Reed, 46 Van Natta 1288 (1994). Dr. Purtzer did not take claimant off work until September 22, 1992. Moreover, claimant has documented chronic back and left leg pain that has persisted since his 1986 injury. We find that Dr. Purtzer's reports indicate that claimant is merely experiencing a continuation of his pain complaints, rather than a suggestion that claimant's compensable condition had worsened. See Emily P. Reed, supra. Therefore, we find that claimant failed to perfect an aggravation claim prior to the expiration of his aggravation rights.[1]

Inasmuch as claimant failed to timely perfect a valid claim for aggravation, the Referee lacked jurisdiction to address the merits. Rather, jurisdiction over this matter is within the Board's own motion jurisdiction.

ORDER

The Referee's order dated January 11, 1994 is vacated. Claimant's request for hearing is dismissed.

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[1] Alternatively, even if claimant perfected an aggravation claim prior to the expiration of his aggravation rights, we are not persuaded that his compensable condition worsened before expiration of his aggravation rights. See Perry v. SAIF, 93 Or App 631, 633 (1988), rev'd on other grounds 307 Or 654 (1989), on remand 99 Or App 52, 55 n.2 (1989). Consequently, even if we examined the merits of claimant's aggravation claim, we would find that he has not established a compensable aggravation claim.

October 5, 1994 Cite as 46 Van Natta 2145 (1994)

In the Matter of the Compensation of
ANTHONY S. SMITH, Claimant
WCB Case Nos. 93-05912 & 93-04995
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Cummins, Brown, et al., Defense 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 upheld the CNA Insurance Companies' (CNA) denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The October 5, 1992 Order and Opinion is the last award or arrangement of compensation regarding the February 8, 1991 work injury. (Ex. 30). Prior to that award, there were no predictions of future flare-ups of claimant's compensable low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, although claimant's low back condition worsened on or about March 17, 1993, resulting in time loss benefits, claimant failed to prove a compensable aggravation claim because: (1) the worsening did not exceed an expected "waxing and waning" of the compensable condition; and (2) a noncompensable motor vehicle accident, which occurred on April 8, 1993, was the major contributing cause of claimant's worsened low back condition after that date. Claimant argues that he established a compensable aggravation claim prior to the noncompensable motor vehicle accident. Claimant also concedes that the motor vehicle accident affected his condition. However, he argues that the length of time the motor vehicle accident remains the major contributing cause of his worsened condition and need for treatment is a matter for determination in a subsequent proceeding. We agree with claimant.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled low back condition, claimant must show that increased symptoms or a worsened underlying condition caused him to be less able to work, thus resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687, rev den 312 Or 150 (1991); Leroy Frank, 43 Van Natta 1950 (1991). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8).

Claimant's last arrangement of compensation was Referee Baker's October 5, 1992 Opinion and Order, which increased claimant's unscheduled permanent partial disability award to 39 percent. (Ex. 30). The impairment rating portion of this award was based on claimant's lumbar surgery and his decreased range of motion. At the time of this award, claimant was able to perform medium/heavy work, with restrictions. (Ex. 30-2).

CNA argues that claimant's condition did not worsen because claimant was never asymptomatic following the February 8, 1991 work injury. We disagree. Although Dr. Lewis, treating orthopedist, opined that claimant's underlying back condition did not worsen, his reports as a whole establish that claimant sustained a symptomatic worsening that made him less able to work.

After not requiring medical treatment for more than five months, claimant returned to Dr. Lewis on March 19, 1993, complaining of severe back pain following his work as a janitor two days earlier.[1] Dr. Lewis noted marked tenderness and decreased ranges of motion in claimant's low back. (Ex. 10-8, -9). Dr. Lewis took claimant off work for the day and released him for light duty work for the next week. (Ex. 10-9). On March 30, 1993, Dr. Lewis noted that claimant was "doing about the same" and released him from all work for two weeks. (Exs. 10-9, 31A). Because claimant was able to perform medium/heavy work, with restrictions, at the time of his last award, we find that Dr. Lewis' releases from work prior to the noncompensable motor vehicle accident represent a diminished earning capacity claimant sustained due to the 1991 work injury.

We note that Dr. Lewis opined that the motor vehicle accident probably worsened claimant's low back condition but that, prior to that accident, claimant did not have a "significant" worsening and that his condition had remained "fairly" stationary. (Exs. 38, 51). However, Dr. Lewis also characterized claimant's pain in March 1993 as "significant," made objective medical findings supporting a symptomatic worsening, and ultimately took claimant off work for two weeks. (Exs. 10-8, -9, 48, 51). Given this and the fact that Dr. Lewis qualified his opinion that claimant did not sustain a worsening before the motor vehicle accident by stating that claimant did not have a "significant" worsening and that he remained "fairly" stationary, we find that Dr. Lewis' opinions as a whole establish that claimant had a symptomatic worsening that resulted in a diminished earning capacity.

Furthermore, Dr. Dinneen, examining orthopedist, opined that claimant had a "net mild worsening" of the February 8, 1991 work injury. (Ex. 52-4). Thus, Dr. Dinneen's opinion supports a symptomatic worsening. The record contains no other medical opinions.

Finally, because claimant has received a permanent disability award for his compensable low back injury, he must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8). In making this determination, we note that a history of past flare-ups alone is insufficient evidence on which to base a finding that waxing and waning of symptoms was contemplated by the previous award of permanent disability. Lucas v. Clark, supra at 106 Or App 690; Linda J. Hughes-Smith, 45 Van Natta 827, 828 (1993); Gary D. Gunter Jr., 44 Van Natta 2198 (1992). There must also be medical evidence predicting such flare-ups. Id.

Here, CNA relies on reports issued by Dr. Lewis after the last arrangement of compensation to

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[1] About March 7, 1993, claimant began working as a janitor for the SAIF Corporation's insured. (Ex. 32). After experiencing increased symptoms during his work on March 17, 1993, claimant sought medical treatment on March 19, 1993. He eventually filed a new injury claim against SAIF, which SAIF denied. (Ex. 40). The Referee upheld SAIF's denial. Claimant did not appeal that portion of the Referee's decision.

support its argument that, if claimant's condition worsened, that worsening was no more than expected waxing and waning. However, Dr. Lewis' statements could not have been considered by Referee Baker when he awarded claimant 39 percent unscheduled permanent partial disability, because those statements were not in existence at the time of the September 15, 1992 hearing. Prior to claimant's symptomatic worsening in March 1993, there was no medical evidence predicting future flare-ups. Thus, the medical evidence in existence at the last arrangement of compensation does not support a finding that the parties and the Referee "contemplated" future waxing and waning of claimant's low back condition at that time. Linda J. Hughes-Smith, supra; John L. Will, 44 Van Natta 1209, 1210 (1992). 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.

Furthermore, CNA's reliance on Luella M. Best, 45 Van Natta 1638 (1993), and Anthony J. Kosmas, 45 Van Natta 1092 (1993), is misplaced, in that, in those cases, unlike the present case, there was medical evidence predicting future problems and exacerbations before the last awards of compensation.

In addition, we note that CNA's claims examiner requested Dr. Lewis' opinion as to whether claimant's condition had worsened in light of his prior award. (Ex. 41). In doing so, she stated that "[t]hat permanent partial disability finding would definitely contemplate waxing and waning of [claimant's] symptoms with or without exertion, given the amount of his PPD [permanent partial disability]." Id. In response, Dr. Lewis stated that claimant's condition had not worsened and was a "waxing and waning of his injury based upon the PPD he's been awarded so far." (Ex. 43). However, as discussed above, the last award of compensation did not contemplate future waxing and waning. Thus, CNA's claims examiner's legal conclusion was inaccurate. Therefore, Dr. Lewis' opinion regarding the lack of worsening in comparison with that award, which was based on that inaccurate legal conclusion, is not persuasive.

To summarize, we find that claimant established a symptomatic worsening of his low back condition resulting in diminished earning capacity. Furthermore, 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.

We note that the April 8, 1993 motor vehicle accident occurred after claimant's compensable condition symptomatically worsened resulting in diminished earning capacity. Furthermore, Dr. Lewis' unrebutted opinion establishes that this motor vehicle accident was the major contributing cause of a worsening of claimant's low back condition and claimant's current need for medical treatment and time loss. (Exs. 38, 43, 48, 51).

Claimant concedes that the motor vehicle accident affected his condition. (Claimant's Appellant's Brief, page 5). However, he argues that the length of time the motor vehicle accident remains the major contributing cause of his worsened condition and need for treatment is a matter for determination in a subsequent proceeding. Id. We agree with claimant that the affect of the subsequent noncompensable motor vehicle accident on claimant's compensable aggravation claim is a claims processing issue that will be addressed in the future. That issue is not presently before us; therefore, we do not address it.

Claimant is entitled to an assessed attorney fee for prevailing on 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 $5,000, to be paid by CNA. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief(s), 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 February 9, 1994 is reversed in part and affirmed in part. That portion of the order that upheld CNA Insurance Companies' denial is reversed. CNA's denial is set aside and the claim is remanded to CNA for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $5,000, payable by CNA.

In the Matter of the Compensation of
ANA J. CALLES, Claimant
WCB Case No. 93-07622
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Referee Schultz' order that awarded a $1,500 assessed attorney fee under ORS 656.382(1) for SAIF's premature determination of vocational assistance ineligibility. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF's March 29, 1993 Notice of Ineligibility for vocational assistance was unreasonable. The Referee determined that because there were no amounts then due at the time of the unreasonable conduct, that claimant was not entitled to a penalty under ORS 656.262(10). The Referee concluded that SAIF's conduct constituted an unreasonable resistance to the payment of compensation because its premature determination of ineligibility restricted claimant's access to vocational assistance. The Referee, therefore, assessed a $1,500 attorney fee pursuant to ORS 656.382(1). We agree.

Subsequent to the Referee's order, we held, in Gustavo Cantu-Rodriguez, 46 Van Natta 1801 (1994), that a carrier-paid attorney fee award under ORS 656.382(1) was available when a carrier unreasonably resisted the payment of compensation by issuing a premature notice of ineligibility of vocational services. In that case, the claimant sought Director review of a carrier's notice that he was ineligible for vocational assistance. The Director set the notice aside as premature, instructing the carrier to redetermine the claimant's eligibility within 30 days of receiving notice of his permanent restrictions. The claimant then sought an attorney fee award under ORS 656.382(1) for the carrier's allegedly unreasonable resistance to the payment of compensation.

We first found that there was a compensable claim and that the carrier's conduct in issuing the premature notice was without legal basis and, therefore, unreasonable. Furthermore, we found that such unreasonable conduct resulted in the resistance of the payment of compensation because the practical effect of the carrier's notice, had it been allowed to stand, would have been to shift the responsibility for obtaining vocational assistance from the carrier to the claimant. We further concluded that "compensation" under ORS 656.382(1) included services for evaluating eligibility for vocational assistance. Therefore, based on this reasoning, we held that the claimant was entitled to an assessed attorney fee under ORS 656.382(1).

Applying the Cantu-Rodriquez holding to this case, we first note that there is no dispute that claimant has a compensable claim. We also adopt the Referee's findings that SAIF's conduct was unreasonable. At hearing, SAIF's vocational coordinator testified that she issued the notice of ineligibility because it was not yet apparent whether claimant would likely have permanent impairment, pursuant to OAR 436-120-040(2), and because claimant's lack of suitable employment could not be resolved by providing vocational assistance, under OAR 436-120-045(10).

OAR 436-120-040(2) requires, as a condition for eligibility for vocational assistance, that "[t]here is medical evidence which indicates that, because of the injury, the worker will likely have a permanent disability." Here, at the time it issued the March 29, 1993 Notice of Ineligibility, SAIF had requested,[1] but had not yet received, information from claimant's treating physician regarding claimant's work

[1] Dr. Weintraub had reported to SAIF, on February 2, 1993, that claimant was not medically stationary and that he doubted claimant would have permanent impairment.

release and her physical capacities. Claimant's treating physician, Dr. Weintraub, responded on April 30, 1993 that claimant was released to modified work with permanent restrictions of limited repetitive use of the right hand. He recommended an insurer-arranged medical examination (IME) for a closing examination. Claimant underwent an IME on May 26, 1993, which found no objective evidence of permanent impairment. On June 14, 1993, Dr. Weintraub concurred with the IME.

Accordingly, not until Dr. Weintraub's June 14, 1993 ratification of the IME impairment findings, did SAIF have sufficient medical evidence regarding claimant's permanent disability. Consequently, we conclude that at the time SAIF issued its March 29, 1993 notice of ineligibility, it had no basis for determining that claimant would not likely have permanent disability. As such, it acted unreasonably in issuing its premature notice of ineligibility.

Furthermore, based on the reasoning in Cantu-Rodriguez, we find that such unreasonable conduct resulted in the resistance to compensation. Thus, we conclude that claimant is entitled to an assessed fee under ORS 656.382(1) and we affirm the Referee's order awarding a $1,500 assessed fee for SAIF's unreasonable resistance to the payment of compensation by means of its premature notice of ineligibility for vocational assistance.[2]

Claimant is not entitled to an attorney fee, on Board review, for defending against the attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

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

Board Member Haynes specially concurring.

Under the doctrine of stare decisis, I am obligated to follow the majority's holding in Gustavo Cantu-Rodriquez, 46 Van Natta 1801 (1994). Nevertheless, I direct the parties' attention to the dissenting opinion in Cantu-Rodriquez. The dissent in Cantu-Rodriquez considered the majority's reasoning both speculative and insufficient to constitute an unreasonable resistance to the payment of compensation. Here, unlike in Cantu-Rodriquez, SAIF redetermined claimant's eligibility and issued a second Notice of Ineligibility after receiving medical evidence that claimant will not likely have permanent disability. Also, unlike in Cantu-Rodriquez, the Director has not yet determined the propriety of SAIF's second (the July 29, 1993) Notice of Ineligibility. Thus, our holding in this case further extends the speculation of whether compensation is due or that the carrier has unreasonably resisted the payment of compensation.

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[2] A June 24, 1993 Notice of Closure closed the claim without an award of permanent disability. On July 29, 1993, SAIF issued a Notice of Ineligibility for Vocational Assistance on the ground that claimant had no permanent disability. On September 13, 1993, claimant requested Director review. Although claimant has not yet been found entitled to vocational assistance, we look at SAIF's conduct at the time it issued the March 1993 notice of ineligibility in determining whether claimant is entitled to an attorney fee under ORS 656.382(1). Because the evaluation of eligibility for vocational assistance constitutes compensation within the meaning of ORS 656.382(1), compensation was due at the time SAIF issued its unreasonable March 1993 notice of eligibility.

In the Matter of the Compensation of
THOMAS D. GILCHRIST, Claimant
WCB Case No. 92-13479
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Galton's order which upheld the self-insured employer's denial of his claim for a myocardial infarction (heart attack). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but offer the following brief summary of the relevant facts.

On August 10, 1992, claimant experienced chest pain while engaged in strenuous work activities unloading a truck in temperatures exceeding 100 degrees. The pain disappeared after a two-hour nap later in the day. The chest pain returned the next day, however, with strenuous work activity in similar temperatures. Claimant testified that, while the weather was hot, his work activities were similar to what he had done in the past and that he had unloaded trucks in warm weather before. (Trs. 8, 12).

When his pain became severe on August 11, 1992, claimant was hospitalized and diagnosed with an anterior myocardial infarction. The employer denied the claim on October 7, 1992. Claimant underwent coronary artery bypass surgery on October 20, 1992.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the medical evidence did not establish that claimant's work exposure was the major contributing cause of a worsening of claimant's underlying, preexisting coronary artery disease. Therefore, the Referee upheld the employer's denial. Claimant contends that the Referee should have analyzed this as an accidental injury claim, requiring application of a material causation standard. Claimant emphasizes that his claim was for a myocardial infarction, not for a worsening of his preexisting coronary artery disease.

Whether allegedly caused by physical exertion, such as in this case, or by job stress, a heart attack is an accidental injury within the meaning of ORS 656.005(7). Claimant's heart attack is compensable if it meets the statutory requirements for accidental injuries. Mathel v. Josephine County, 319 Or 235 (1994).

According to Dr. Brodeur, a physician who examined medical records on claimant's behalf, physical exertion during claimant's employment caused arteriosclerotic plaque from preexisting coronary artery disease to rupture, obstructing blood flow to claimant's heart muscle and producing myocardial muscle damage, i.e., a myocardial infarction (heart attack). (Exs. 21, 24). We construe such evidence as showing that claimant has preexisting coronary artery disease that allegedly combined with work activity to produce a myocardial infarction.

Therefore, claimant must prove that work activity was the major contributing cause of his myocardial infarction in order prove the compensability of his accidental injury claim. See ORS 656.005(7)(a)(B); Steven W. Coons, 46 Van Natta 1438 (1994); William J. McAdams, 45 Van Natta 785 (1993). Because of the various potential causes of myocardial infarctions, we conclude that the medical causation question requires expert medical evidence for its resolution. Thurston v. Mitchell Bros. Contractors, 58 Or App 568, 575 (1982).

There are three medical opinions that address the cause of claimant's myocardial infarction. Dr. Toren, a cardiologist who is Board certified in cardiovascular diseases, examined claimant on behalf of the employer. (Ex. 14). He explained that a myocardial infarction occurs when blood flow through a

coronary artery ceases. Dr. Toren classified heart attacks into two categories: (1) those occurring as a result of an acute change in coronary artery anatomy due to rupture of arterial plaque leading to coronary thrombosis; and (2) those in which the coronary arteries have not changed immediately prior to the myocardial infarction. Dr. Toren explained that the former category of heart attacks is far more common (85 to 95 percent of all cases) and bears no relationship to the patient's activities. Most such infarctions occur during sleep, rest or minimal activities.

According to Dr. Toren, in the less common type of myocardial infarction, where the arteries have not changed immediately prior the heart attack, the patient experiences an acute imbalance of supply and demand of blood caused by either a marked increase in demand or a lack of available blood flow from either blood loss or reduction of cardiac output. The acute imbalance can occur as a result of severe exertion or a singular episode of emotional stress. Dr. Toren emphasized that physical exertion would have to be considerably in excess of that normally experienced.

Based on several factors, Dr. Toren concluded that claimant's heart attack fell into the first category of myocardial infarctions relating to acute disruption of chronic coronary artery plaque. First, the vast majority of heart attacks, according to Dr. Toren, are of this type. Second, claimant's EKG showed a Q-wave pattern consistent with this mechanism. Third, claimant experienced a period of unstable angina prior to his myocardial infarction, which was most consistent with plaque rupture and coronary thrombosis.

Dr. Toren ruled out the less common type of myocardial infarction, which can occur in cases of physical exertion, because claimant's physical exertion was not substantially in excess of that customarily undertaken and claimant's two-day history of chest pain was inconsistent with an exertion-related, imbalance-of-supply-and-demand heart attack. Dr. Toren concluded that it was not medically probable that claimant's work played a material or major role in the development of claimant's underlying coronary artery disease.

Dr. DeMots, another cardiologist, conducted a records review for the employer. A Professor of Medicine and Head of the Cardiology Division at Oregon Health Sciences University, Dr. DeMots opined that claimant's work activities were not the major contributing cause of his heart attack. According to Dr. DeMots, physical exercise is not a risk factor for coronary artery disease, which was the cause of claimant's heart attack. (Ex. 18). In a subsequent report, Dr. DeMots stressed that the majority of heart attacks occur while people are sleeping or at rest. Thus, Dr. DeMots opined the process of plaque formation and rupture in coronary arteries operates essentially independently of the external environment.

At the request of claimant, Dr. Brodeur, also a cardiologist, conducted a records review. Dr. Brodeur's qualifications are not documented in the record. However, he concluded that claimant's work activities were the major contributing cause of his myocardial infarction. (Ex. 21). Dr. Brodeur explained that physical exertion can cause plaque to rupture in coronary arteries through a mechanism called "shearing force." He wrote that "shearing force" caused by exertion can play a role in either of the two categories of heart attacks described by Dr. Toren.

In a subsequent report, Dr. Brodeur submitted supporting medical literature. (Ex. 24). In one cardiology textbook article, the author reported that there was "suggestive evidence" that heavy exercise may play a precipitating role in heart attacks. The author notes, however, that adequate control studies have not been carried out. (Ex. 24-8). In an article on the "Pathology of Unstable Angina," another author wrote that computer models have suggested that hemodynamic stresses associated with heartbeat, bending and twisting of an artery, or increase in pressure related to exercise or coronary tone "may contribute" to fissuring of plaque. (Ex. 24-6).

Claimant contends that Dr. Brodeur's medical opinion is the most persuasive regarding the cause of his myocardial infarction because, unlike Dr. Brodeur, Dr. Toren and Dr. DeMots only discussed the usual causes of heart attacks and did not adequately address his particular circumstances. We disagree.

Dr. Toren examined claimant and took a detailed history regarding the circumstances of his heart attack. Although he devoted considerable attention to describing the distinctions between the two categories of heart attacks, Dr. Toren applied his general knowledge of the causes of myocardial

infarctions to claimant's specific heart attack. Dr. Toren explained why he did not believe that claimant's heart attack was work related based on a thorough and accurate history and on a detailed analysis of the causation issue.[1] Because it is thoroughly explained and well-reasoned, Dr. Toren's opinion is quite persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. DeMots is an eminently qualified physician, whose medical opinion supports Dr. Toren's. In his expert opinion, physical exertion is almost never related to myocardial infarctions. While Dr. Brodeur strongly disagrees with Dr. Toren and Dr. DeMots regarding the cause of claimant's heart attack, his expertise is not as well documented as Drs. Toren's and DeMots'.

More importantly, the medical literature that Dr. Brodeur submitted is not sufficiently definitive as to the causal nexus between physical exertion and myocardial infarctions. The textbook article on which Dr. Brodeur relies states that there is only "suggestive" evidence of a causal connection and notes that adequate control studies have not been carried out. The other article on "shear stress" is similarly based on suggestive evidence that exercise "may" contribute to fissuring of arterial plaque. For these reasons, the weight of Dr. Brodeur's opinion is diminished. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

In conclusion, we find that claimant has failed to sustain his burden of proving that his work activities are the major contributing cause of his need for treatment for his myocardial infarction.[2] See ORS 656.005(7)(a)(B). Because claimant has not met his burden of proof, we conclude that his claim is not compensable.

ORDER

The Referee's order dated December 10, 1993 is affirmed.

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[1] Claimant asserts that Dr. Toren's opinion ought to be discounted because he based it on the erroneous assumption that there was nothing extraordinary about claimant's work activities on August 10 and 11, 1992. We are persuaded, however, that Dr. Toren had an accurate history.

Dr. Toren described the nature of claimant's work activities in his report. He characterized the hooking and unhooking of trailers as "moderately heavy" work. However, Dr. Toren wrote that claimant's work activities were "customary" for him. Claimant's testimony supports Dr. Toren's understanding of the nature of his work. Claimant confirmed that his work activities were "typical" and that he had unloaded trucks in warm conditions in the Southwest before. (Trs. 8, 12). We agree with Dr. Toren that claimant's work activities were not substantially in excess of what claimant customarily performed.

[2] Assuming arguendo that a material causation standard were applicable as claimant suggests, we would still conclude that claimant has failed to satisfy his burden of proof based on the persuasive medical opinions of Drs. Toren and DeMots.

In the Matter of the Compensation of
JERRY B. MATHEL, Claimant
WCB Case No. 90-18752
ORDER ON REMAND
Rasmussen & Henry, Claimant Attorneys
Bostwick, et al., Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Mathel v. Josephine County, 319 Or 235 (1994). In our prior order, Jerry B. Mathel, 44 Van Natta 1113, on recon 44 Van Natta 1532 (1992), we upheld the self-insured employer's denial of claimant's myocardial infarction. In doing so, we analyzed the claim under ORS 656.802(1) pursuant to SAIF v. Hukari, 113 Or App 475, rev den 314 Or 391 (1992). Reasoning that the claim should be analyzed as an accidental injury under ORS 656.005(7)(a), the Court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In August 1990, after experiencing two days of abnormally high emotional stress at work, claimant suffered a myocardial infarction. The Referee found the condition compensable. On review, we initially affirmed, reasoning that the claim should be treated as an accidental injury and that claimant had carried his burden of proving that work activities were a material contributing cause of his myocaridal infarction. Jerry B. Mathel, supra.

However, on reconsideration, we concluded that the claim properly was analyzed under ORS 656.802, following the decision in SAIF v. Hukari, supra. Jerry B. Mathel, supra. In Hukari, the court held that any claim that a condition is independently compensable because it was caused by on-the-job stress must be treated as a mental disorder claim under ORS 656.802(3). We found Hukari applicable because claimant based his claim on the assertion that job stress caused his hypertension, which in turn resulted in a heart attack. In the absence of a diagnosed mental disorder, we concluded that the claim failed. See ORS 656.802(3)(c).

The Court of Appeals affirmed. Mathel v. Josephine County, 122 Or App 424 (1993). The Supreme Court, however, after examining the relevant statutes, held that a heart attack, whether caused by physical exertion, job stress, or both, is an accidental injury within the meaning of ORS 656.005(7)(a) rather than a mental disorder under ORS 656.802(3). Mathel v. Josephine County, supra. Therefore, the Court reversed the decision of the Court of Appeals and remanded to the Board for further proceedings. We proceed with our reconsideration.

Inasmuch as the claim is for a myocardial infarction, or heart attack, we treat it as an accidental injury. Id. Thus, claimant must prove that his employment was a material contributing cause of his myocardial infarction in order to prove compensability. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). The medical record regarding causation consists of opinions from Dr. Crowley, claimant's treating cardiologist, and Dr. Kremser, who examined claimant on behalf of the employer.

Dr. Kremser attributed claimant's heart attack to "malignant hypertension," which she found to have resulted from renal artery stenosis. (Ex. 5). Dr. Kremser based her opinion on early test results showing evidence of significant renal artery stenosis. However, after claimant underwent more extensive and accurate testing, those results proved that he did not have renal artery stenosis. (Exs. 6-1, 7-1). Therefore, having been based on information that was later proved to be inaccurate, we give little weight to Dr. Kremser's opinion. See Somers v. SAIF, 77 Or App 259 (1986).

As evidenced by his concurrence with a letter from claimant's attorney, Dr. Crowley concluded that "the cause of [claimant's] heart attack was stress-caused hypertension directly related to his [job] duties and responsibilities[.]" (Ex. 8-1). Absent persuasive reasons to the contrary, we are inclined to defer to Dr. Crowley's opinion as the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983).

As asserted by the employer, we acknowledge that Dr. Crowley provided little explanation for his opinion. (Ex. 4A). However, unlike that of Dr. Kremser, Dr. Crowley had an accurate understanding of claimant's condition. Furthermore, Dr. Crowley oversaw a variety of tests, including an ECG, blood tests, and a treadmill stress test. Finally, having found Dr. Kremser's opinion unpersuasive and in the absence of other opinions concerning causation, Dr. Crowley's opinion is unrebutted. Therefore, finding no persuasive reasons for not deferring to Dr. Crowley's opinion, we rely on it. See Weiland v. SAIF, supra. Thus, based on Dr. Crowley's opinion, we conclude that claimant established the compensability of his claim. See ORS 656.005(7)(a).

Claimant has finally prevailed after remand with respect to the compensability of his myocardial infarction. 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). In the event that claimant prevailed after remand, the Supreme Court's appellate judgment directs that claimant's attorney shall be awarded a fee in the amount of $23,250.

On reconsideration, the Referee's order dated April 30, 1991, as reconsidered July 12, 1991, is affirmed. In accordance with the Supreme Court's directive, claimant's attorney is awarded a fee of $23,250, payable by the employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
CALVIN R. MOOTRY, JR., Claimant
WCB Case No. 93-13045
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Thye's order that affirmed an Order on Reconsideration awarding 22 percent (70.4 degrees) unscheduled permanent disability for a left shoulder injury. On review, the issue is extent of unscheduled permanent disability.

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

The Order on Reconsideration found that claimant was entitled to 5 percent for acromion resection and 1 percent for loss of abduction of the left shoulder. See OAR 436-35-330(14), 436-35-330(5) (WCB Admin. Order 6-1992). Because these values resulted in 6 percent impairment, the Referee found that claimant was not entitled to chronic condition impairment. See OAR 436-35-320(5)(a) (providing that chronic condition impairment may not be awarded only if the "total unscheduled impairment within a body area is equal to or in excess of 5%"). The Referee rejected claimant's argument that his award of 5 percent for the acromion resection should not be considered under OAR 436-35-320(5)(a), finding that such value qualified as "impairment" under the rule.

On review, claimant reiterates his argument that his award for the acromion resection should not be considered as "impairment" under OAR 436-35-320(5)(a). Claimant relies on OAR 436-35-005(5), which defines "impairment" as a "decrease in the function of a body part or system as measured by a physician[.]" According to claimant, his award for the acromion resection was based merely on the fact that he had the surgical procedure rather than on any decrease in function of his left shoulder that resulted from the surgery.

We first note that the definition of impairment in OAR 436-35-005(5) applies to rules 436-35-001 through 436-35-450 "unless the context requires otherwise." As provided in OAR 436-35-320(1), OAR 436-35-320 through 436-35-440 "give standards for rating physical impairments which might lead to an award for loss of earning capacity." (Emphasis added.) OAR 436-35-280(1) also requires the determination of "the basic value which represents impairment, using OAR 436-35-320 through 436-35-440."

We first find that, inasmuch as OAR 436-35-320(1) and 436-35-280(1) directly speak to the rating of impairment, the context otherwise requires us to follow these rules rather than the definition provided in OAR 436-35-005(5). Based on OAR 436-35-320(1) and 436-35-280(1), we further find that any rating or value derived from OAR 436-35-320 through 436-35-440 should be considered "impairment."

Our approach is consistent with that taken in Robert L. Todd, 43 Van Natta 418 (1991). In that case, the insurer argued that the claimant was not entitled to any social or vocational values because, inasmuch as the claimant's only impairment was loss of repetitive use of his back, he had no "measurable impairment" under former OAR 436-35-270(2). In so contending, the insurer relied on former OAR 436-35-005(1), which provided the same definition of "impairment" as the current OAR 436-35-005(5).

The Board rejected the insurer's argument, finding that the context otherwise required that OAR 436-35-005(1) not be applied. Specifically, the Board found that awards provided under the section entitled "Impairments Rated as Unscheduled Disability" (former OAR 436-35-320 through 436-35-440) qualified as "impairment" and that the specific rule for loss of repetitive use expressly identified such an award as "impairment. Thus, the Board determined that claimant's award for loss of repetitive use was "impairment" for purposes of entitlement to values for social and vocational factors.

Therefore, we hold that the "acromion resection" award based on OAR 436-35-330(14) should be considered "impairment" for purposes of determining whether claimant is entitled to unscheduled chronic condition impairment under OAR 436-35-320(5)(a). Because claimant's total unscheduled impairment in the left shoulder is 6 percent, there is no entitlement to chronic condition impairment. See OAR 436-35-320(5)(a).

ORDER

The Referee's order dated February 25, 1994, is affirmed.

In the Matter of the Compensation of
JAY A. NERO, Claimant
WCB Case No. 92-04986
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Nero v. City of Tualatin, 127 Or App 458 (1994). The court reversed that portion of our prior order, Jay A. Nero, 45 Van Natta 1082 (1993), which held that claimant was not entitled to a penalty under ORS 656.268(4)(g) when an Order on Reconsideration granted 12 percent unscheduled permanent disability and 11 percent scheduled permanent disability. Concluding that such a penalty is based on all compensation due on a claim, including combined awards for scheduled and unscheduled permanent disability, the court has remanded for reconsideration.

The relevant facts are as follows. A Notice of Closure awarded claimant no permanent disability. On reconsideration, claimant was awarded 12 percent unscheduled and 11 percent scheduled permanent disability, for a total of 23 percent permanent disability. The amount of compensation awarded claimant for permanent disability was increased on reconsideration from zero to $8,872.50. Claimant was not awarded a penalty on reconsideration.

The employer requested a hearing on the Order on Reconsideration. The Referee reduced the unscheduled permanent disability award from 12 percent to 5 percent, and the scheduled permanent disability award from 11 percent to zero. The Referee also declined to assess a penalty under ORS 656.268(4)(g).

Claimant requested Board review. We reinstated and affirmed the permanent disability compensation awarded by the Order on Reconsideration. Jay A. Nero, supra. We did not assess a penalty under ORS 656.268(4)(g).

In reaching our decision, we reasoned that the statute was ambiguous on the question of whether scheduled and unscheduled permanent disability awards could be combined to satisfy the "20 percent permanent disability" requirement for a penalty under the statute. Relying on OAR 436-35-050(13), which provides for a penalty where the combined award totals 64 degrees, we declined to assess a penalty because claimant's combined award was less than 64 degrees.

The court has reversed our decision. Nero v. City of Tualatin, supra. Perceiving no ambiguity in the statutory language, the court reasoned that the legislature's reference to "compensation" in the statute was intended to refer to the entire claim, including combined awards for scheduled and unscheduled permanent disability. Consequently, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

ORS 656.268(4)(g) 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. All compensation due a claimant under the claim is to be considered in determining whether the statutory requirements for assessing a penalty have been met. Nero v. City of Tualatin, supra. If both conditions are met, but the Department has not assessed a penalty, we are authorized to do so under ORS 656.268(4)(g). Steven L. Cline, 46 Van Natta 512 (1994).

Here, on reconsideration, claimant was awarded 11 percent scheduled and 12 percent unscheduled permanent disability. Together, the awards total 23 percent permanent disability. Therefore, we conclude that the statutory requirement that claimant be at least 20 percent permanently disabled has been satisfied.

The second requirement is also satisfied, since on reconsideration, claimant's compensation for permanent disability was increased from zero, representing an increase of at least 25 percent. Therefore, claimant is entitled to a penalty under ORS 656.268(4)(g) equal to 25 percent of the amount of compensation due to claimant on reconsideration.

Accordingly, on reconsideration of the "penalty portion" of our June 18, 1993 order, we reverse the "penalty portion" of the Referee's order dated July 10, 1992. The self-insured employer is assessed a penalty equal to 25 percent of the compensation awarded on reconsideration (12 percent unscheduled permanent disability and 11 percent scheduled permanent disability for the right leg), payable by the employer directly to claimant.

IT IS SO ORDERED.

October 6, 1994 Cite as 46 Van Natta 2156 (1994)

In the Matter of the Compensation of
PATRICIA B. PETERSON, Claimant
WCB Case No. 93-11748
ORDER OF DISMISSAL
Silven, Schmeits, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant has requested review of Referee Podnar's June 30, 1994 order. Contending that claimant did not timely request review of the Referee's order, the self-insured employer has moved for dismissal. The motion is granted.

FINDINGS OF FACT

The Referee's order issued on June 30, 1994, reversing an Order on Reconsideration award of 5 percent scheduled permanent disability for loss of use or function of the left forearm. On August 4, 1994, the Board received claimant's counsel's August 1, 1994 "Request for Hearing and Specification of Issues." The request raised as issues unscheduled and scheduled permanent disability. That request was acknowledged by the Hearings Division and given a new WCB case number (94-09353).

On September 12, 1994, the Board received claimant's counsel's September 7, 1994 letter announcing that claimant's request for hearing was intended to be a request for Board review of the Referee's June 30, 1994 order. Inasmuch as that request had been "completed within the thirty (30) days and was probably apparent to opposing counsel that the matter was incorrect in that he filed a response citing preclusion," claimant's counsel stated that claimant wished to "amend" her request for hearing to become a request for Board review.

On September 14, 1994, the employer moved to dismiss claimant's hearing request in WCB Case No. 94-09353. The employer contended that claimant was precluded from seeking permanent disability by virtue of the Referee's June 30, 1994 order. Finally, the employer objected to claimant's attempt to transform her hearing request into a timely filed request for Board review of the Referee's June 30, 1994.

On September 20, 1994, Presiding Referee Tenenbaum "dismantled" the "new" WCB case file created in response to claimant's August 1, 1994 hearing request. Referee Tenenbaum also referred the employer's objections to claimant's "amendment request" to the Board.

On September 22, 1994, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

The request for review by the Board of a Referee's order need only state that the party requests review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Donna M. Munoz, 43 Van Natta 1712 (1991); Gerardo V. Soto Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

In reaching our conclusion as to whether claimant timely requested Board review of the Referee's June 30, 1994 order, we find the Munoz decision particularly instructive. In Munoz, rather than filing a request for Board review of a Referee's "May 21, 1991 order," the claimant's counsel filed a hearing request concerning a "May 21, 1991 denial." In concluding that the claimant had failed to timely appeal the referee's order, we rejected the claimant's contention that her hearing request actually constituted a request for Board review of the referee's order. In doing so, we reasoned that the claimant's request was both clear and unmistakable; i.e., she was requesting a hearing before the Hearings Division, not requesting Board review of a referee's order.

Here, as in Munoz, claimant acknowledges that her counsel's office incorrectly filed a hearing request when she intended to file a request for Board review of the Referee's order. Likewise, as in Munoz, she asks us to consider her hearing request as actually a request for Board review. Consistent with the Munoz holding, we are unable to interpret claimant's August 1, 1994 request in such a manner. The intention expressed in the aforementioned request (presented on a Board "Hearing Request" form) is both clear and unmistakable; i.e., claimant was requesting a hearing before the Hearings Division, not requesting Board review of the Referee's June 30, 1994 order. Consequently, we hold that claimant's August 1, 1994 request does not constitute a request for Board review of the Referee's order.

Claimant's counsel's September 7, 1994 letter does express an intention to request review of the Referee's June 30, 1994 order. Thus, that letter, which was received by the Board on September 12, 1994, does constitute a request for Board review. However, September 12, 1994 is more than 30 days after the Referee's June 30, 1994 order. Therefore, the request for review is untimely. ORS 656.289(3); 656.295(2)

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH CANTRELL, Claimant
WCB Case No. C4-02248
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Member Neidig and Hall.

On September 6, 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, and add the following concerning a revision in the Department of Consumer and Business Services's (Department) rules.

Former OAR 436-60-145(4)(e) stated:

"The claim disposition agreement shall also contain, but not be limited to, the following: The worker's age, highest education level, and the extent of vocational training."

Effective August 28, 1994, the Department issued WCD Admin. Order 94-055, revising OAR 436-60-145. OAR 436-60-145(4)(e) now states in pertinent part:

"The claim disposition agreement shall also contain, but not be limited to, the following: The worker's age, highest education level, and the extent of vocational training, including a list of occupations * * *. (Emphasis added)."

Thus, the revised rule requires two items concerning a claimant's vocation: the extent of training and a list of occupations claimant has held. OAR 436-60-145(4)(e).

Here, the CDA states in part:

"The worker has been trained to perform the following vocation(s): homebuilder (framer)." (P.3, ln. 7)."

We note that, although the CDA lists the vocations in which claimant has been trained, it does not indicate whether claimant has worked in those occupations and/or other occupations. Accordingly, a CDA providing such language would not be in compliance with the Department's new rule. Nevertheless, because this CDA contains at least one signature from a party dated before the Director's rules became effective, we find that the CDA in this instance is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved. An attorney fee of $187.50, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

October 7, 1994 Cite as 46 Van Natta 2158 (1994)

In the Matter of the Compensation of
BRYCE A. CARSON, Claimant
WCB Case No. 93-10222
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Lipton's order that: (1) excluded testimony of one of SAIF's witnesses; (2) set aside SAIF's denial of claimant's claim for a right ankle injury; and (3) assessed a penalty for an allegedly unreasonable denial. Claimant cross-requests review of that portion of the Referee's order that assessed a 25 percent penalty for an unreasonable denial based on amounts due as of the date of denial. On review, the issues are evidence, 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

Compensability

On August 11, 1993, just as claimant was beginning his shift, he went into a large freezer, slipped on a wet/icy floor, caught his ankle and fell. A co-worker, Mr. Oaks, was also in the freezer. Although he did not see claimant actually fall, he heard claimant yell out profanities, slap down a pallet very hard, and saw claimant limping out of the freezer.

SAIF argues that claimant did not fall in the freezer but, rather, fell at a later time while engaging in horseplay with another worker. Specifically, SAIF contends that claimant walked past Mr. Huffine, a co-worker, and twisted Mr. Huffine's hat. Then, when Mr. Huffine approached claimant to do the same to claimant's hat, both workers fell to the floor.

Reasoning that there was no testimony contradicting claimant's testimony concerning his first fall in the freezer, the Referee concluded that claimant's fall in the freezer was a compensable injury. Even if Mr. Huffine accurately described claimant's second fall outside the freezer, the Referee determined that the incident did not constitute horseplay. We affirm.

Claimant must establish that he suffered an accidental injury arising out of and in the course of employment which was a material contributing cause of his disability or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Injuries arising from horseplay are not compensable unless a claimant shows a causal link between the occurrence of the injury and a risk connected with his or her employment. Brown v. Liberty Northwest Ins. Co., 105 Or App 92 (1990).

Claimant's first ankle injury was witnessed by Mr. Oaks. Mr. Oaks stated that, considering what he had heard, and then seeing claimant limp out of the freezer, he believed that claimant had fallen. (Tr. 5, Feb. 23, 1994).

SAIF argues that Mr. Oaks' testimony carries little weight because he was fired shortly after the incident. However, Mr. Oaks related the same account of what he witnessed to SAIF's investigator on August 19, 1993, prior to being fired. Additionally, Mr. Oaks testified that, when operations manager, Mr. Slate, was discussing Mr. Oaks potential testimony concerning claimant's fall, Mr. Oaks had the impression that Mr. Slate was attempting to sway Mr. Oaks' testimony in favor of the employer. Accordingly, because we are persuaded by the testimony of Mr. Oaks, and because the record contains no persuasive evidence to the contrary concerning claimant's fall in the freezer, we conclude that claimant experienced a right ankle injury when he fell in the freezer at work on August 11, 1993.

SAIF next contends that claimant injured his right ankle while engaging in horseplay with Mr. Huffine.

Claimant testified that, after he fell in the freezer, he was limping toward the break room and passed by Mr. Huffine, who had his back to claimant. Near Mr. Huffine was another co-worker, Mr. Boggess, who was doing some paperwork as claimant went by. Claimant did not think Mr. Boggess saw him as claimant walked by, so claimant turned back toward Mr. Boggess to tell him about the injury. (Tr. 33). As claimant approached the vicinity of Mr. Boggess and Mr. Huffine, Mr. Huffine was backing toward claimant. Claimant put out his arm to prevent Mr. Huffine from backing into him. When claimant touched Mr. Huffine, Mr. Huffine spun around and both workers fell to the floor. (Tr. 34). Mr. Boggess saw both workers as they were on the floor, but did not see them fall to the floor. (Tr. 82).

Mr. Huffine testified that claimant walked by him, "ruffled" his hat and continued past. (Tr. 111). Mr. Huffine then went over to claimant, ruffled his hat, and claimant turned and fell. (Tr. 113). Mr. Huffine then stated that, when claimant turned and fell, Mr. Huffine "went back to pulling the rolls in and then that was about it." (Tr. 113). Subsequently, Mr. Huffine altered his testimony to state that he also fell when claimant fell. (Tr. 114). Mr. Huffine also testified that he was not sure whether claimant had injured his ankle before or after the fall with Mr. Huffine. (Tr. 120).

We tend to agree with claimant's version of the incident with Huffine in that we consider it unlikely that claimant would be in a "playful" mood after just having injured his ankle in the freezer. In any event, even accepting Mr. Huffine's description of the incident over claimant's, the record establishes that, more likely than not, claimant's fall in the freezer is a material cause of his ankle injury. Claimant first gave a history of a fall in the freezer to the emergency room physician. He then related the same history to Dr. Sedgewick, treating surgeon. (Ex. 17). Accordingly, we conclude that claimant has met his burden of proving that he sustained a compensable right ankle injury on August 11, 1993.

Evidence

SAIF objects to the Referee's exclusion of the testimony of Mr. Heath, day shift supervisor, concerning claimant's mood or demeanor when he arrived at work on the day of injury. SAIF also objects to the Referee's rejection of the testimony of night shift supervisor, Mr. Kasch, as not

credible. The Referee concluded that Mr. Heath's opinion regarding claimant's demeanor had no bearing on whether claimant had engaged in horseplay or sustained a work injury. We review the Referee's conclusions for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

SAIF contends that Mr. Heath's testimony is relevant to SAIF's horseplay defense because it shows that claimant's attitude was hostile and reckless, and disputes claimant's assertion that he was in a hurry to perform his work, which resulted in his fall in the freezer. We need not resolve these evidentiary rulings because, even if we considered the excluded testimony, we would continue to find that claimant's ankle condition is materially related to a work injury.

Unreasonable Denial

The Referee found SAIF's denial unreasonable and assessed a penalty of 25 percent of the amounts due at the time the denial issued. ORS 656.262(10). We agree that the denial was unreasonable, but modify the basis for the penalty.

SAIF contends that it had a legitimate doubt concerning compensability of claimant's injury when it issued its denial. We disagree.

Pursuant to ORS 656.262(10), claimant is entitled to a penalty if the insurer or self-insured employer "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

The alleged work incident occurred on August 11, 1993. Claimant filed his claim on August 17, 1993. SAIF issued its denial on August 24, 1993. SAIF's investigator interviewed Mr. Huffine and Mr. Oaks on August 19, 1993. (Tr. 115; Tr. 12, Feb. 23, 1994). Mr. Huffine described the alleged "horseplay" incident. Mr. Oaks related that he had heard claimant fall in the freezer. The employer had not issued a citation for any "horseplay" violation. Furthermore, SAIF had in its possession the emergency room report and subsequent medical reports from Dr. Sedgewick, treating surgeon, stating that claimant hurt his ankle when he fell in the freezer. Accordingly, notwithstanding the fact that SAIF also had Mr. Huffine's account alleging that the two had engaged in horseplay, we conclude that SAIF did not have a legitimate doubt concerning claimant's work injury.

The Referee assessed a penalty of 25 percent of the amounts due at the time the denial issued. However, we modify the Referee's award to assess a 25 percent penalty pursuant to ORS 656.262(10) for the insurer's unreasonable denial, to be shared equally by claimant and his counsel. This penalty shall be based on all amounts of compensation 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).

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 $950, 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. Claimant is not entitled to a carrier-paid fee for services related to the penalty issue.

ORDER

The Referee's order dated March 10, 1994, as supplemented on September 1, 1994 by an interim Order on Remand, is modified in part and affirmed in part. In lieu of the Referee's penalty assessment, the SAIF Corporation is assessed a penalty equal to 25 percent of the amounts due at the time of the January 18, 1994 hearing as a result of the Referee's order. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $950, payable by SAIF.

In the Matter of the Compensation of
BRENDA GUZMAN, Claimant
WCB Case No. 93-11840
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that affirmed a Determination Order which classified her claim as nondisabling. In its brief, the SAIF Corporation argues that the Referee lacked jurisdiction since claimant did not request reconsideration of the Determination Order prior to requesting a hearing. On review, the issues are jurisdiction and classification. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

SAIF contends that the Referee lacked jurisdiction over this matter since claimant did not request reconsideration of the September 29, 1993 Determination Order prior to requesting a hearing. We disagree.

On January 22, 1993, claimant injured her right forearm while employed by the employer as a nursery worker. SAIF initially denied the claim, but later rescinded its denial and accepted the claim as nondisabling for a contusion and sprain of the right wrist. Claimant requested review by the Department of SAIF's nondisabling classification. On September 29, 1993, a Determination Order issued which ordered that the claim remain classified as nondisabling.

In support of its argument that the Referee lacked jurisdiction to address the reclassification issue, SAIF relies on OAR 436-30-045(7). That rule provides:

> "(7) Pursuant to ORS 656.277, claims for nondisabling injuries will be processed by the Department in the same manner as claims for disabling injuries and if either party objects to the determination of Evaluation as to the worker's disabling/nondisabling status, that party must request a reconsideration by the Appellate Unit in accordance with ORS 656.268 before requesting a hearing under ORS 656.283."

In Walter T. Driscoll, 45 Van Natta 391 (1993), we held that there was no statutory requirement that a claimant first request reconsideration of a Determination Order which addressed a request for reclassification of a claim accepted as nondisabling. Based on the statutory scheme and the plain language of the statutes, we concluded in Driscoll that the reconsideration process set forth in ORS 656.268(5) and (6) was limited to accepted disabling claims. In reaching our decision in Driscoll, we interpreted ORS 656.262(6)(c), 656.268(9) and 656.268(11) as granting the claimant a right to request a hearing directly from a Determination Order which addresses claim reclassification.

Based on our holding in Driscoll, we conclude that OAR 436-30-045(7) is inconsistent with the statutory scheme because it requires a claimant to request reconsideration prior to requesting a hearing on a Determination Order addressing claim classification. Accordingly, inasmuch as the rule conflicts with the statutory scheme, we give it no effect. See Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992) (An agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule).

Reclassification

Having found that we have jurisdiction, we now address the classification issue. Claimant raises two arguments in support of her contention that her claim should be reclassified as disabling. First, claimant contends that her release to modified work establishes that she is temporarily partially disabled, even though the rate of her temporary partial disability (TPD) would be zero since she earned her regular wages while performing modified work. On this basis, claimant argues that she has established that her claim is disabling. Second, claimant contends that she has established that there is a substantial likelihood that she will be entitled to an award of permanent disability.

On January 23, 1993, Dr. Braddock released claimant to light duty for five days. Dr. Braddock defined light duty as wearing a wrist splint. Dr. Miller, claimant's treating doctor for the forearm condition, first saw claimant on January 28, 1993. He recommended that claimant continue light duty work. Claimant's employer was aware of Dr. Braddock's recommendation that claimant wear a wrist splint at work. To comply with Dr. Braddock's restriction, the employer placed claimant in a modified job in which claimant worked five days operating a stop watch and timing production. No repetitive use of the arms or hands was required and claimant wore a wrist brace during the work activities. Dr. Miller released claimant to regular work on February 4, 1993. Claimant returned to her regular job on February 24, 1993.

Finding that no temporary benefits were due and payable, and that claimant was not substantially likely to be entitled to permanent disability under the standards, the Referee concluded that claimant had not established that her claim should be classified as disabling.

As we previously noted, claimant contends that she was temporarily partially disabled because she was released to modified work. On this basis, claimant contends that her claim was disabling even though she received the same wages for her modified work that she received at her regular work. SAIF does not dispute that claimant was released to a modified job, but argues that no temporary disability benefits were "due and payable" in this claim and that, based on ORS 436-30-045(5)(a), claimant's claim is not disabling. OAR 436-30-045(5)(a) provides that a claim is "disabling" if temporary disability is "due and payable."

Subsequent to the date of the Referee's order, we issued our decision in Sharman R. Crowell, 46 Van Natta 1728 (1994). In Crowell, we held that a claimant's receipt of regular wages for her modified work did not preclude a finding that the claimant's injury was disabling. In reaching that conclusion we relied on Stone v. Whittier Wood Products, 124 Or App 117 (1993) which held that temporary partial disability (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 Crowell, the claimant was released to modified work at her pre-injury wage. We held that even though the rate of the claimant's TPD might be zero, the mere fact that the claimant was required by the compensable injury to work at modified employment meant that she was temporarily and partially disabled.

Thus, we concluded in Crowell that the claimant was disabled as a result of her injury, notwithstanding the fact that she might receive TPD at the rate of zero once her TPD was calculated. We emphasized in Crowell that the issue was whether the claim was disabling, not whether temporary disability was due and payable. We also found OAR 436-30-045(5)(a) inconsistent with the court's holding in Stone v. Whittier Wood Products, supra, since the rule equated disability with reduction in post-injury wages.

Here, because claimant was released to modified work, we conclude that her claim was disabling, notwithstanding the fact that she may receive TPD at the rate of zero once her TPD is calculated. Sharman R. Crowell, supra.

Finally, SAIF notes that, in response to the court's decision in Stone v. Whittier Wood Products, supra, the Department promulgated temporary rules for determining whether a worker who is released to a modified job is entitled to TPD. SAIF argues that under those temporary rules claimant has not proven that she would be entitled to TPD. However, the issue before us is not the extent of claimant's temporary and/or permanent disability. Rather, the issue before us is whether claimant's claim should be classified as disabling. We have found that claimant is entitled to TPD, even though the rate of TPD may be zero. Accordingly, claimant's claim is disabling. The extent of claimant's temporary or permanent disability is an issue to be decided at claim closure.

ORDER

The Referee's order dated January 6, 1994 is reversed. The Determination Order is set aside. SAIF is directed to reclassify the claim as disabling and process it according to law. Claimant's attorney is awarded 25 percent of the increased compensation, if any, resulting from this order, not to exceed $3,800, payable directly by SAIF to claimant's attorney.

In the Matter of the Compensation of
JOAN LASKI, Applicant
WCB Case No. CV-94003
ORDER ON REVIEW (CRIME VICTIM ACT)
Diane M. Brissenden, Assistant Attorney General

Joan Laski, (hereinafter "applicant"), sought Board review of the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated January 20, 1994. By its order, the Department denied compensation to applicant under the Compensation of Crime Victim Act (ORS Chapter 147).

A hearing was set in the above referenced matter for May 26, 1994. On May 25, 1994, applicant contacted the Board to request a postponement. Based on applicant's representation that she had recently been hospitalized, the hearing was postponed. The hearing was rescheduled for June 16, 1994. On that date, applicant informed the Board that she would be unable to attend the hearing due to her participation in a treatment program. Applicant further informed the Board that she had completed two weeks of a six-week program, and would not be able to attend a hearing until the program was complete. Based on that representation and with the Department's agreement, applicant's hearing was postponed for a second time.

By letter dated June 22, 1994, the special hearings officer requested that applicant select a preferred hearing date, in order for a hearing to be re-scheduled. In that letter, applicant was advised that, in light of the prior requests for postponement, a further postponement would not likely be granted. Applicant did not respond to the June 22, 1994 letter. By letter dated August 10, 1994, applicant was again requested to select a hearing date. The letter informed applicant that, if no response was received by August 24, 1994, applicant's case would be decided on the record.

Having received no response from applicant within the time period set forth in the August 10, 1994 letter, review is conducted based solely on the record.

ISSUE

Whether applicant is entitled to benefits under ORS Chapter 147.

FINDINGS OF FACT

Applicant lived with a friend, Joy, and her friend's husband, Robert Gambrel (Gambrel). According to a subsequent police report, applicant stated that the Gambrels had been having problems, and Joy obtained a restraining order against her husband. Applicant reported to the police that, on May 6, 1993, applicant attempted to serve a restraining order on Gambrel, an altercation ensued between applicant and Gambrel, and the police were called. Gambrel was arrested and applicant was taken by ambulance to a hospital emergency room for treatment.

Dr. Anderson, emergency room physician, took a history from applicant that she had been assaulted with fists and struck with a lamp by her friend's "father." Applicant also reported having been choked by the suspect, but stated that she did not lose consciousness. Applicant stated that she drank approximately one-half pint of vodka while waiting for the police to arrive and arrest Gambrel.

Dr. Anderson reported that he found no trauma to applicant's scalp, no visible bruise to the face and no strangulation marks on the neck. He further found that applicant could move her neck fully and had only some soft tissue tenderness in the left trapezius, with some superficial skin wounds. Dr. Anderson's final diagnosis of applicant's condition was "neck strain" and "superficial wounds." As treatment, Dr. Anderson prescribed over-the-counter aspirin or ibuprofen.

According to the police report, Gambrel had a bite mark on the middle finger of his right hand. The officer noted that applicant's face was red and puffy, she had two lumps on the back of her head, and she complained of severe neck and back pain. Applicant informed the police officer that when she attempted to serve a restraining order on Gambrel, he became angry and immediately attacked her. According to applicant, Gambrel knocked her to the ground, punched her face and beat her head on the floor. Gambrel's wife also provided a statement at that time indicating that Gambrel had knocked applicant to the ground.

In the police report, Gambrel denied attacking applicant and stated that she had not given him a restraining order. Gambrel told the police officer that he had not hit applicant, but applicant had jumped on him and bit his finger. Charges filed against Gambrel were eventually dismissed.

In her application for crime victims' compensation, applicant stated that after serving Gambrel with a restraining order, he would not leave the premises, so she called 911. Applicant stated that Gambrel then ripped the phone out of her hands, knocked her down, grabbed her by the throat and started to strangle her until she passed out.

On October 11, 1993, the Department issued its order which denied applicant's claim on the basis that, due to conflicting statements, applicant did not meet the eligibility criteria set forth in ORS 147.015(1). Claimant requested reconsideration of the Department's order. On January 20, 1994, the Department issued its Order on Reconsideration which declined to reverse the original order.

The Department's Order on Reconsideration provided that "additional information" gathered from the District Attorney's office as a result of applicant's reconsideration request suggested a third version of the assault or fight. The reconsideration order referred to a taped statement of a conversation between applicant and Gambrel's defense attorney. According to the District Attorney's office, applicant stated on tape that the confrontation occurred when applicant went to the assistance of her friend when she heard Gambrel and her friend arguing in their room. Applicant further stated that she was set up by the wife and honestly could not remember who threw the first punch. Finally, the Department's order found that the District Attorney had dismissed the case against Gambrel, due to the inconsistent versions of the case as provided by applicant to the police and the defense attorney.

On March 18, 1994, the Board received applicant's request for review of the Department's order. In her requet for review, applicant stated that she was denied benefits due to her conversation with Gambrel's attorney. Applicant further stated that on the night of the incident, she had been pushed down, struck, choked and hit with a lamp. Applicant also stated that, although she had discussed the incident with Gambrel's attorney, she had had quite a bit of alcohol to drink and did not remember the entire conversation.

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases appealed to the Board under the act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015(1), applicant is entitled to an award under the act if, among other requirements, she is a victim of a compensable crime that resulted in a compensable loss of more than $100. ORS 147.015(1). "Compensable crime" means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4).

Here, there are several versions of the incident involving applicant and Gambrel. Applicant's version in support of her application for crime victim benefits essentially states that she was serving a restraining order on her friend's husband, as requested by her friend. Applicant contends that, once served with the restraining order, Gambrel became angry, ripped a phone out of her hands, knocked her down, grabbed her by the throat and started to strangle her until she passed out.

On the other hand, Gambrel has denied attacking applicant and has stated that he was not served with a restraining order. Rather, Gambrel stated that applicant attacked him while he was in his bedroom talking to his wife. Gambrel stated to the police that applicant jumped on him and bit his finger.

We find that applicant's statement in support of her petition for benefits is inconsistent with other descriptions of the incident that appear in the record. The inconsistencies appear not only between the versions described by applicant and Gambrel, but are also found in applicant's own description of the incident to different individuals.

First, applicant apparently told Gambrel's attorney that she went to the assistance of her friend when she heard arguing in the bedroom. Applicant also apparently stated to Gambrel's attorney that she believed she was set up by her friend, and she could not remember who threw the first punch.

Applicant's statement to the attorney resulted in the District Attorney dismissing the case due to applicant's inconsistent versions of the event. We also find applicant's description of the event to have varied. Specifically, applicant's statement that she entered the room to serve a restraining order on Gambrel is inconsistent with her taped statement that she entered the room when she heard an argument in progress. Applicant's taped statement also indicates, for the first time, that applicant believed she was "set up" by her friend, Gambrel's wife. Finally, applicant's taped statement that she could not remember who threw the first punch is at odds with her prior statements that Gambrel began the attack.

Furthermore, applicant has disagreed with the description of her statement to Gambrel's attorney. However, in light of claimant's admitted alcohol consumption on that day, we find it more reasonable to rely on the taped statement described by the District Attorney's office, rather than applicant's memory of what was or was not said during that conversation.

Additionally, we particularly rely on the hospital admitting report in resolving the issue of whether applicant's version of events is supported in the record. The admitting report is of assistance due to the fact that the emergency room doctor had the opportunity to observe applicant and to speak to her within a short time after the incident. Furthermore, the doctor who treated applicant had no interest in assigning blame for the incident. Finally, the information provided to the doctor came directly from applicant. See Steve F. Hilden, 45 Van Natta 1673 (1993).

Dr. Anderson's report provided that applicant was "assaulted with fists and struck with a lamp by her friend's father." Dr. Anderson also reported that applicant "complains of being beaten severely by her friend's father." Applicant told Dr. Anderson that she had been choked but did not lose consciousness. Finally, applicant admitted to Dr. Anderson that she had consumed one-half pint of vodka after the incident.

The statement taken by Dr. Anderson varies from applicant's other statements in several respects. First, the suspect was the husband of applicant's friend, not her father. Applicant also told Dr. Anderson that she was struck with a lamp, but neither the police report taken from applicant after the altercation nor applicant's statement in support of her request for benefits mention that she had been struck by a lamp. Additionally, although applicant informed Dr. Anderson that she did not lose consciousness during the altercation, in her application for benefits, applicant stated that she had been strangled or choked by Gambrel until she passed out.

Dr. Anderson's statement also suggests that applicant's description of the event was not consistent with her observable injuries. Applicant informed the arresting officer that she was knocked to the ground, punched in the face, and her head was beaten against the floor. Applicant stated to Dr. Anderson that she had also been struck with a lamp and choked. However, Dr. Anderson reported that, although applicant complained of being beaten severely, there were no signs of trauma to the scalp, no strangulation marks on the neck, no visible bruise to the face and applicant had full range of motion in her neck. Dr. Anderson's conclusion indicates that, despite applicant's description of the incident, he found "minimal signs of objective injury."

Finally, the accuracy of applicant's version of the incident must also be viewed in light of the fact that she had consumed, in her own estimation, approximately half a pint of vodka prior to giving her statement to the police. For this additional reason, it is difficult to rely on the applicant's description of events that night. See Barrie W. Munger, 43 Van Natta 1718 (1991).

It is applicant's burden to establish her entitlement to benefits. Based on the varying statements regarding applicant's role in the incident, as well as the statements concerning how the incident occurred, and the lack of medical findings to support applicant's version of the event, we are unable to conclude that applicant was the victim of a compensable crime. Consequently, applicant has not established her entitlement to benefits.

In conclusion, we recognize the trauma that this incident has caused applicant. Yet, to recover benefits as a victim of a crime under the Act, the Legislature has mandated that several prerequisites must be satisfied. One of those requirements is that applicant must have been the victim of a compensable crime as defined by the statute. For the reasons detailed above, the record does not support such a conclusion. Inasmuch as applicant's claim does not satisfy the statutory requirement for receiving benefits under the Act, she is not entitled to benefits.

The October 11, 1993 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered January 20, 1994, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL J. MOODY, Claimant
WCB Case No. 93-10032
ORDER ON REVIEW
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Michael V. Johnson's order that dismissed his request for hearing regarding termination of his vocational services. In his brief, claimant submits evidence not considered at hearing. We treat this as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and jurisdiction.

We deny the motion for remand and adopt and affirm the Referee's order with the following supplementation.

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

We conclude that claimant has not established a compelling reason for remand. Claimant has submitted with his brief a January 3, 1994 letter from Ms. Shuhart to claimant, and a February 16, 1994 "To Whom It May Concern" letter from Mr. Blucher. Since neither letter pertains to the merits of the jurisdictional issue, they are not reasonably likely to affect the outcome of the case. Thus, we deny the motion for remand.

With respect to the merits of the jurisdictional issue, we agree with the Referee's decision to dismiss claimant's request for hearing regarding the termination of vocational services. Claimant failed to seek administrative review of either the June 24, 1993 "NOTICE OF END OF ELIGIBILITY FOR

VOCATIONAL ASSISTANCE" or the "NOTICE OF END OF TRAINING ON 6/24/93," both of which were issued by claimant's vocational counselor, Mr. Davis. Inasmuch as claimant failed to timely seek administrative review of June 24, 1993 notices that terminated claimant's vocational services, the Referee properly dismissed claimant's request for hearing for lack of jurisdiction. See ORS 656.283(2).

Prior to issuance of the termination notices listed above, claimant had informally sought assistance from a vocational consultant for the Rehabilitation Review Unit of the Dispute Resolution Section of the Workers' Compensation Division. Claimant was concerned about several warning letters he had received and wished to change vocational counselors. On June 23, 1993, he informed the vocational consultant, Ms. Przybylowski, that he wished to discontinue the informal process he had initiated. Ms. Przybylowski then issued an Order of Dismissal on June 25, 1993, which advised claimant that he could request a hearing with the Hearings Division.

Although claimant did request a hearing with regard to the June 25, 1993 dismissal order, this did not vest jurisdiction in the Hearings Division to review the termination of claimant's vocational services. We agree with the Referee that Ms. Przybylowski merely rendered informal assistance. In addition, her assistance preceded issuance of the notices that formally terminated claimant's eligibility for vocational assistance. Therefore, we also agree with the Referee that claimant's prior contact with Ms. Przybylowski did not constitute an appeal to the Director of the subsequent June 24, 1993 notices that terminated claimant's vocational assistance.

Finally, we do not consider claimant to be unsophisticated in vocational assistance matters as the record indicates that claimant had been involved in two administrative reviews prior to hearing. He had previously appealed a termination of vocational assistance in 1988 and restored his eligibility through the administrative process. Claimant also commenced administrative review of a vocational assistance matter in 1992. Claimant even concedes that he made an error in not appealing the termination notices issued by Mr. Davis.

Under these circumstances, claimant's failure to timely appeal the June 24, 1993 termination of vocational assistance to the Director deprives the Board of jurisdiction in this matter. ORS 656.283(2). The Referee properly dismissed claimant's hearing request.

ORDER

The Referee's order dated December 23, 1993 is affirmed.

In the Matter of the Compensation of
SHIRLEY M. SANDEN, Claimant
WCB Case No. 93-12413
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Spangler's order which increased claimant's scheduled permanent disability award for loss of use or function for the right wrist from 1 percent (1.5 degrees), as awarded by Order on Reconsideration, to 2 percent (3 degrees). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the Referee's order. See Kathleen L. Hofrichter, 45 Van Natta 268 (1993)(physician's recommendation that claimant avoid certain motions at work to prevent an increase in symptoms was insufficient to establish permanent and chronic impairment of the back); Rae L. Holzapfel, 45 Van Natta 1748 (1993) aff'd mem Holzapfel v. M. Duane Rawlins, Inc., 127 Or App 208 (1994)(physician's recommendation that the claimant avoid repetitive strenuous work with hands to prevent an increase in symptoms was insufficient to establish a permanent and chronic impairment of the wrists); Donald E. Lowry, 45 Van Natta 1452 (1993).

ORDER

The Referee's order dated January 19, 1994 is affirmed.

Board Member Gunn specially concurring.

Although constrained by the doctrine of stare decisis to follow the Board's prior decisions, I write to express my dissatisfaction with the Board's holding in Donald E. Lowry, 45 Van Natta 1452 (1993). As explained in my dissenting opinion in Mark A. Roberts, 46 Van Natta 1168, 1169 (1994), I believe that a claimant establishes a chronic condition award when the record establishes that her pain complaints require a modification in activities.

Here, although claimant was able to continue to perform her regular work activities, her physician recommended that she occasionally modify the level of her hand movements to avoid her pain. I submit that such evidence should be sufficient to establish a partial loss of ability to repetitively use a body party as required by OAR 436-35-010(6) to support a "chronic condition" award. However, since such a conclusion is inconsistent with the reasoning expressed in Lowry and its progeny, I must adhere to those rulings.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 93-08427
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of our September 8, 1994 Order on Review that: (1) awarded claimant temporary total disability benefits from June 20, 1993 until such benefits could be terminated according to law; and (2) assessed a penalty for the insurer's unreasonable termination of temporary disability benefits. For the following reasons, we adhere to our September 8, 1994 order.

The insurer first contends that the Referee found claimant not credible, and consequently, we should not accept claimant's testimony that he did not receive the employer's offer of modified work. The insurer argues that it necessarily follows that claimant received the employer's work offer, and the employer was entitled to terminate claimant's temporary disability benefits when claimant did not respond to the offer.

We do not agree with the insurer's contention that claimant's credibility is dispositive with respect to this issue. There has been minimal testimony regarding claimant's receipt of the modified work offer. Moreover, even if we were to find claimant noncredible on the issue, the record nonetheless fails to establish that claimant was given the modified work offer. Inasmuch as such a finding is statutorily required to justify termination of temporary disability benefits under ORS 656.268(3)(c), we continue to conclude that the insurer's unilateral termination was not authorized.

The insurer next argues that we erred in finding that Dr. Sedgewick, rather than Dr. Barnhouse, was claimant's attending physician. The insurer argues that, because claimant is not credible, we should not rely on his testimony that he referred himself to Dr. Barnhouse to obtain a second opinion.

For the reasons enumerated in our prior order, we continue to find that Dr. Barnhouse was claimant's attending physician. Additionally, we find that the more important issue is whether claimant received a written release to regular work from his attending physician. Here, regardless of our determination of the status of Dr. Barnhouse, the record does not support a finding that claimant received or was given a written release to work from his attending physician. Therefore, because it has not been established that claimant received an offer of modified work, or that he was given a written release to work from his attending physician, the insurer was not entitled to terminate temporary disability benefits pursuant to ORS 656.268(3)(b).

Finally, the insurer argues that we incorrectly assessed a penalty for an unreasonable termination of temporary disability benefits, as it has established that claimant was offered modified work. We continue to conclude that a penalty is appropriate. As stated above, we are not persuaded that claimant was given a release to modified work by his attending physician. Consequently, it follows that claimant was not properly offered modified work as contemplated by ORS 656.268(3).

Furthermore, in unilaterally terminating temporary disability benefits, the insurer is required to comply with ORS 656.268(3). Here, we find no evidence that the insurer knew that claimant had received the employer's modified work offer. Because the statute requires the carrier to provide claimant with such an offer, the insurer's termination of claimant's benefits did not strictly comply with the statute and the insurer's actions were unreasonable.

Accordingly, we withdraw our September 8, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our September 8, 1994 Order on Review. The parties' rights of appeal shall begin to run from this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM T. SMITH, Claimant
WCB Case No. 93-04941
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of his current heart condition. On review, the issue is compensability. We affirm.[1]

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On review, claimant characterizes SAIF's denial as a "back-up" denial and argues that SAIF accepted his underlying coronary disease in 1974. In support of his argument, claimant points to the fact that SAIF paid for two of claimant's bypass surgeries and did not appeal a Determination Order which awarded permanent total disability. Based on these facts, claimant argues that SAIF accepted claimant's underlying heart condition in 1974. We disagree.

Payment of compensation alone is not enough to establish that SAIF accepted the claim. See ORS 656.262(9) (Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability). The statute specifically prohibits us from finding that an acceptance occurred based merely on the fact that SAIF paid claimant's medical and surgical bills and his permanent disability award. Claimant raises no "circumstances" in this case other than SAIF's payment of compensation to support his argument that SAIF accepted claimant's underlying coronary condition. Accordingly, we do not find that SAIF accepted claimant's claim merely because it paid claimant's compensation.

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[1] Member Gunn has previously argued that heart attacks are symptoms of coronary artery disease. See John Q. Emmert, supra (Board Member Gunn dissenting). Alas, that position has not been considered or adopted by the court.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987).

The August 27, 1974 notice of claim acceptance did not identify any particular condition that was being accepted. (Ex. 6). Rather, it accepted a disabling injury identified only by a code designation which meant "chest strain." When the specific condition accepted is not identified by the notice, we look to the contemporaneous medical records to determine what was accepted. John Q. Emmert, 44 Van Natta 997 (1994).

Here, claimant was admitted to the hospital on July 12, 1974 after suffering severe chest and left arm pain at work. Claimant's diagnosis on discharge from the hospital was "acute anteroseptal myocardial infarction." (Ex. 3). Thus, we conclude, based on the contemporaneous medical records, that "acute anteroseptal myocardial infarction" is the condition accepted by SAIF in August 1974.

Finally, claimant argues that his accepted myocardial infarction was a symptom of his underlying coronary artery disease. See Georgia-Pacific v. Piwowar, 305 Or 494 (1988). On this basis, claimant contends that SAIF accepted his underlying coronary disease. We disagree. The record contains no competent medical evidence which would support a conclusion that claimant's accepted myocardial infarction was merely a symptom of his underlying coronary disease. See John Q. Emmert, supra; Howard L. Chant, 45 Van Natta 8 (1993).

Having found that the scope of SAIF's acceptance did not include the underlying coronary disease, we turn to the merits of SAIF's current condition denial.

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 cause claimant's current condition. Rather, the medical evidence addressing causation focuses on whether the 1974 mycocardial infarction is causally related to claimant's current coronary condition and need for treatment. Accordingly, the applicable standard is the major contributing cause standard. See ORS 656.005(7)(a)(A).

Dr. DeMots, cardiologist, opined that the 1974 myocardial infarction is not the cause for any current treatment claimant may require. Rather, DeMots opined that claimant's current medical treatment is related to the underlying coronary artery disease.

Dr. Reinke, a cardiologist who treated claimant, opined that claimant's current cardiac condition was not caused by claimant's 1974 myocardial infarction. (Ex. 25-23). Dr. Reinke believed that atherosclerosis was the major contributing cause of claimant's current heart condition. (Ex. 25-18).

Dr. Trenholme, cardiologist, opined that there has been a progression of claimant's coronary artery disease since 1974 which is unrelated to the 1974 myocardial infarction. Dr. Trenholme felt that claimant's continued smoking has been a major contributing factor to his ongoing coronary artery disease. Trenholme further opined that claimant's subsequent decrease in cardiac function and congestive heart failure were related to the progression of claimant's coronary artery disease and not due solely to the original myocardial infarction in 1974. (Ex. 22). Dr. Trenholme had earlier identified both claimant's 1974 myocardial infarction as well as the the subsequent progression of the coronary artery disease, both in the saphenous vein grafts, as well as his native circulation, as "the major or contributing causes" of claimant's continuing disability and need for therapy. We interpret Dr. Trenholme's opinion to mean that the 1974 myocardial infarction was a material contributing cause of claimant's current condition. However, we are unable to conclude, based on Dr. Trenholme's references to other significant contributing factors, that he believed that the 1974 myocardial infarction was the major contributing cause of claimant's current coronary condition.

Dr. Gross, a cardiologist who was also involved in claimant's treatment, felt that if claimant had a large infarction in 1974, prior to his admission to the hospital with a small infarct, claimant's present disability could be related in a major way to the 1974 event. (Ex. 20-2). Dr. Gross's opinion is based on a possibility, rather than a probability of a causal connection and is, therefore, not sufficient to establish compensability.

After reviewing the record, we rely on the opinion of Dr. Reinke, treating cardiologist, which is supported by the opinion of Dr. DeMots, that claimant's current cardiac condition is not causally related to his 1974 myocardial infarction. Accordingly, claimant has not established compensability of his current condition and need for treatment.

ORDER

The Referee's order dated January 11, 1994 is affirmed.

In the Matter of the Compensation of
MARTIN STROME, Claimant
WCB Case No. 93-00013
ORDER ON REVIEW
Coons, et al., 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 T. Lavere Johnson's order which: (1) set aside its denial of claimant's injury claim for left neck, left shoulder, and left arm condition; (2) awarded interim compensation from December 4, 1992 through December 22, 1992; and (3) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. In its brief, the employer contends that Exhibits 18, 19, and 21 should have been admitted. On review, the issues are evidence, compensability, entitlement to interim compensation, 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

Evidentiary Matters

The employer contends that the Referee abused his discretion in excluding Exhibits 18, 19, and 21. Exhibit 18 is a May 14, 1993 spinal range of motion findings completed by a physical therapist for purposes of a closing examination. Exhibit 19 is Dr. Serbu's May 24, 1993 concurrence with those findings. Exhibit 21 is a July 28, 1993 report from Dr. Serbu regarding the history provided by claimant concerning the October 22, 1992 accident and regarding Dr. Serbu's opinion of claimant's range of motion findings. The employer asserts that these exhibits were relevant to show further inconsistencies in claimant's history of his claim.

ORS 656.283(7) provides that "the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See, e.g. Brown v. SAIF, 51 Or App 389 (1981). Evidence is relevant if it has a tendency to make the existence of any fact that is of consequence to the determination more or less probable. Phil Sanders, Jr., 45 Van Natta 1607, 1608 (1993).

After our review of the records, we agree with the Referee that the proferred exhibits concerned claimant's extent of disability and were irrelevant to the compensability issue. Alternatively, even if the exhibits were admitted, the result regarding the compensability issue would be the same. Therefore, we find that the Referee did not abuse his discretion by excluding these exhibits.

Compensability

We adopt and affirm the Referee's findings and conclusions regarding the compensability of claimant's claim.

Interim Compensation

The Referee found that claimant left work due to the neck, left shoulder and left arm condition on December 4, 1992, the date diagnostic studies were performed. The Referee, therefore, concluded that claimant was entitled to interim compensation from December 4, 1992 until December 22, 1992, the date of the denial. We modify.

Claimant first sought treatment for his left arm, neck, and left shoulder condition, on November 6, 1992, from Dr. Larson. Dr. Larson released claimant from work on that date. Claimant filed a Form 801 on November 18, 1992, giving the date of injury as October 22, 1992. The Form 801 also indicated that the employer first knew of the injury on November 18, 1992. Thus, the employer was obligated to begin payment of interim compensation within 14 days of its knowledge of the claim. ORS 656.262(4)(a). However, there is no duty to pay such compensation if claimant has not left work pursuant to ORS 656.210(3). See Bono v. SAIF, 298 Or 405 (1984).

Here, claimant continued to perform his regular work until his scheduled vacation a few days before Thanksgiving. Claimant remained on that vacation when he saw Dr. Serbu on December 2, 1992 for a neurosurgical consultation. Claimant underwent a diagnostic myelogram on December 4, 1992. Dr. Serbu performed surgery on December 8, 1992. Inasmuch as claimant did not testify as to when his scheduled vacation was to end, the record does not conclusively establish when he left work due to his compensable injury. ORS 656.266. Claimant, however, remained off work following the surgery. The employer concedes that claimant left work due to his injury at the time of his surgery on December 8, 1992. Thus, under these circumstances, for purposes of ORS 656.210(3), we find that claimant left work due to the injury on that date. Therefore, claimant was entitled to interim compensation from December 8, 1992 to December 22, 1992. The Referee's order is modified accordingly.

Penalty for Failure to Pay Interim Compensation

The employer asserts that interim compensation was not due until 14 days from December 16, 1992, the date it received Dr. Serbu's December 8, 1992 surgical report. The employer denied the claim on December 22, 1992. Thus, the employer contends that it had a legitimate doubt as to its liability for payment of interim compensation because it it had denied the claim within 14 days of knowledge of claimant's surgery.

As discussed above, the triggering date for evaluating entitlement to interim compensation is the date the employer had notice or knowledge of the claim. ORS 656.262(4)(a). The employer's liability for interim compensation attached when it received notice of the claim, on November 18, 1992, although it was not obligated to begin payment of interim compensation until claimant left work due to his injury. The employer provides no explanation for its failure to begin payment of interim compensation commencing the date claimant "left work" as a result of his compensable injury (December 8, 1992) once it received Dr. Serbu's surgery report on December 16, 1992. Based on the record, we find that the employer's failure to pay interim compensation from December 8, 1992 to December 22, 1992 was unreasonable.

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

ORDER

The Referee's order dated December 7, 1993 is affirmed in part and modified in part. In lieu of the Referee's award of interim compensation from December 4, 1992 to December 22, 1992, claimant is entitled to such compensation from December 8, 1992 to December 22, 1992. Claimant's attorney's "out-of-compensation" fee payable from this award shall be modified accordingly. The remainder of the order is affirmed. For services on Board 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
ELIECER VEGA, Claimant
WCB Case No. 93-08731
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Menashe's order which declined to direct the insurer to pay an additional 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of the right leg as allegedly granted by an Order on Reconsideration. The insurer cross-requests review of that portion of the order which assessed a 25 percent penalty for the insurer's allegedly unreasonable failure to pay the additional 7 percent scheduled permanent disability pursuant to the Order on Reconsideration. On review, the issues are claim processing and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and offer the following brief summary of the pertinent facts.

Claimant sustained a compensable right knee injury on October 1, 1991. The insurer issued a Notice of Closure on November 10, 1992, which awarded 7 percent ($3,202.50) scheduled permanent disability for loss of use or function of the right leg. On May 3, 1993, 174 days later, claimant requested reconsideration and appointment of a medical arbiter. After a June 19, 1993 medical arbiter's examination, a July 21, 1993 Order on Reconsideration was issued. It provided:

"THE TOTAL SCHEDULED AWARD TO DATE FOR THE FOLLOWING BODY PART(S) IS:

"14 PERCENT EQUAL TO 21 DEGREES FOR THE RIGHT LEG (KNEE).

"******

"THE INSURER IS ORDERED TO PAY THE WORKER AN AWARD OF $6,405.00. THIS IS IN ADDITION TO ANY PREVIOUS AWARDS."

On July 26, 1993, the Hearings Division received claimant's request for hearing from the reconsideration order. On that same date, the Appellate Unit received the insurer's request to correct the dollar amount of the permanent disability award in its order. Following the July 21, 1993 reconsideration order, the insurer had paid an additional 7 percent ($3,202.50) scheduled permanent disability. This payment brought claimant's total scheduled permanent disability to 14 percent.

On August 4, 1993, the Appellate Unit issued an amended reconsideration order which directed the insurer to pay an award of $3,202.50. On October 4, 1993, more than 180 days after the November 1992 Notice of Closure, the insurer cross-appealed the award of permanent disability in the July 21, 1993 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the August 4, 1993 amended reconsideration order, reasoning that the Appellate Unit had no authority under OAR 436-30-008(1) to change the July 21, 1993 reconsideration order after claimant's request for hearing. Finding that claimant was not substantively entitled to more than 14 percent scheduled permanent disability, the Referee reduced accordingly the dollar amount of the July 1993 reconsideration order's award of permanent disability. The Referee, nevertheless, assessed a 25 percent penalty on the additional 7 percent scheduled permanent disability the insurer did not pay pursuant to the July 21, 1993 reconsideration order. Reasoning that the insurer knew that the Appellate Unit had no authority to correct the erroneous reconsideration order after claimant had requested a hearing, the Referee found the insurer's conduct in not paying all of the permanent disability required by the July 21, 1993 reconsideration order to have been unreasonable.

Claim Processing

Inasmuch as it is uncontested that the insurer had previously paid the 7 percent permanent disability award granted by the Notice of Closure, it is apparent that the July 21, 1993 Order on Reconsideration's directive to pay a dollar amount equivalent to an "additional" 14 percent scheduled permanent disability was inconsistent with that portion of the reconsideration order which stated that claimant's "total" award was 14 percent.

On review, claimant contends that he is entitled to payment of the additional 7 percent scheduled permanent disability ($3,202.50) awarded by the July 21, 1993 reconsideration order. Claimant argues that the insurer's duty to fully pay the permanent disability award was neither stayed nor dissolved pending claimant's hearing request. We agree the duty to pay was not stayed or dissolved (and for that reason we award a penalty), but for the following reasons, we cannot direct the insurer to pay the additional 7 percent award because claimant is not entitled to it.

In Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the court held that the Board was precluded from creating an administrative overpayment of benefits by directing a carrier to pay temporary disability (TTD) beyond the claimant's medically stationary date as found by a Determination Order (DO) that claimant had unsuccessfully appealed. In this case, claimant does not dispute the Referee's finding that claimant is only entitled to 14 percent scheduled permanent disability. Thus, were we to order the insurer to pay an additional 7 percent scheduled permanent disability, when it had already paid claimant's 14 percent award in full, we would create an overpayment of permanent disability benefits to which the claimant is not substantively entitled. Under the Seiber rationale, we are prevented from doing so.

Anodizing, Inc. v. Heath, 129 Or App 352 (1994) does not change the result. In Heath, the court affirmed the Board's order in John R. Heath, 45 Van Natta 840 (1993), that awarded the claimant TTD payable from the date of a carrier-appealed reconsideration order (which had set aside a Determination Order (DO) as premature) until the date of a referee's order reversing the reconsideration order. Reasoning that the claimant was not ultimately found entitled to TTD for the disputed period (because the DO had been subsequently reinstated on appeal), the carrier argued that the Board was not authorized to order payment of the TTD. The carrier cited Lebanon Plywood v. Seiber, supra. Relying on Roseburg Forest Products v. McDonald, 116 Or App 651 (1992), the claimant contended that ORS 656.313(1)(a)(A) required payment of the TTD payable from the reconsideration order pending the carrier's appeal.

After reviewing the two decisions, the court made the following distinction between them. In Seiber, there had been no carrier appeal pursuant to ORS 656.313 and the claimant had not been statutorily entitled to TTD beyond the medically stationary date. Under such circumstances, the Heath court reasoned that the Board was without authority to order the payment of TTD which should have been procedurally paid through the date of a DO because to do so would create an overpayment. In contrast, the Heath court concluded that, in McDonald, the carrier had appealed a DO's TTD award and, despite the eventual reversal of that award, the claimant was statutorily entitled under ORS 656.313 to these benefits pending the carrier's appeal.

Finding McDonald controlling, the Heath court held that the claimant was statutorily entitled to the TTD (payable as a result of the reconsideration order which had set aside the DO) during the appeal process regardless of the outcome of the appeal. See ORS 656.313(1)(a)(A). Unlike the situation in Seiber, the Heath court determined that no overpayment had resulted, in that, had the carrier paid the TTD during the appeal, it would not be entitled to recoup any of those benefits despite the reversal of the reconsideration order.

Here, claimant contends that the insurer was required to pay the "additional" 7 percent award pending his hearing request from the Order on Reconsideration because the insurer failed to timely appeal the reconsideration order. Again, we agree with claimant that the carrier's duty to pay the compensation was neither stayed nor abrogated pending appeal and for that reason a penalty is being assessed. The issue now, however, is whether claimant is now legally entitled to the additional 7 percent or whether an order requiring such payment would impermissibly create an overpayment.

In reaching our conclusion, we find this case more similar to Seiber than to Heath or McDonald. To begin, since the insurer did not timely appeal the July 21, 1993 reconsideration order, this case only involves a claimant's appeal of the order. Therefore, this case, like Seiber, is not governed by ORS 656.313, as claimant himself concedes.

In contrast, McDonald and Heath involved carrier appeals under ORS 656.313. Thus, the claimants in those cases were entitled statutorily to the temporary disability benefits in question, regardless of the outcome of the eventual decision concerning the merits. ORS 656.313(1)(a)(A). However, in this case, the claimant is not now statutorily entitled to the additional 7 percent permanent disability. The Referee did not find that claimant is entitled to 21 percent scheduled permanent disability, nor is there a provision in ORS 656.313 that requires payment of the additional 7 percent permanent disability regardless of the outcome of claimant's appeal.

Moreover, even if ORS 656.313 was applicable to this case, this dispute, unlike the dispute in Heath, does not pertain to "prospective" TTD, which must be paid pending appeal. The current version of ORS 656.313 does not include an exception to its stay of compensation provisions for permanent disability. Thus, like the claimant in Seiber, claimant here is not statutorily entitled to the benefits in dispute, regardless of whether or not ORS 656.313 applies. While it was unreasonable for the insurer not to have paid the additional permanent disability benefits (see discussion below), we can not now award the additional 7 percent permanent disability, because to do so would constitute a prohibited overpayment under Seiber.

Claimant's citation to Glen D. Roles, 45 Van Natta 282 (1993) does not assist him. As our order in Roles makes clear, that case, which also involved a carrier's obligations to pay temporary disability pending its appeal of a referee's order, was governed by McDonald and ORS 656.313. Because this case does not involve ORS 656.313 and is controlled by Seiber, Roles is inapposite.

Inasmuch as we find that Seiber is controlling, we conclude that the Referee did not err in declining to order the insurer to pay the additional 7 percent scheduled permanent disability to which claimant was not substantively entitled. Accordingly, we affirm the Referee's decision on this issue.

Penalty Issue

The insurer contends that its reliance on the amended Order on Reconsideration was not unreasonable. Therefore, the insurer reasons that the Referee erred in assessing a 25 percent penalty for its failure to pay the additional 7 percent scheduled permanent disability ($3,202.50) erroneously awarded in the July 21, 1993 reconsideration order. We disagree.

OAR 436-30-008(1) provides that the Appellate Unit can change an order in the case of an inadvertent error, such as what apparently occurred in this case. However, the administrative rule also provides that the Appellate Unit can only act if there has been no request for hearing. See also Marvin Thrasher, 45 Van Natta 565 (1993) (subsequent abatement of reconsideration order does not moot appeal of "abated" order).

Here, claimant requested a hearing regarding the reconsideration order before the Appellate Unit could clarify claimant's permanent disability award. In light of this apparent ambiguity in the reconsideration order and claimant's prompt hearing request (necessary because of the limited time within which to satisfy the 180-day appeal period under ORS 656.268(6)(b)), the insurer's options were admittedly limited. It could file a request for hearing within 6 days of the July 21, 1993 reconsideration order (thereby triggering the automatic stay provisions of ORS 656.313) or it could pay the additional award.

However, the insurer did not request a hearing within 6 days of the July 21, 1993 reconsideration order, nor did it do so within 30 days of the reconsideration order pursuant to OAR 436-60-150(6)(c). The insurer also failed to pay the additional award when it became due 30 days after the July 31, 1993 reconsideration order. Under these circumstances, we agree with the Referee that the insurer's conduct was unreasonable and that a 25 percent penalty was appropriate. See Gene G. Martin, 45 Van Natta 2102, 2104 (1993) (failure to pay permanent disability awarded by reconsideration order unreasonable where no request for hearing filed within 30 days of issuance of order). This penalty is based on the additional 7 percent scheduled permanent disability award "then due" at the time of the insurer's untimely hearing request.

The insurer's reliance on Forney v. Western States Plywood, 297 Or 628 (1984) does not change the result. In Forney, the Court held that an employer does not act unreasonably when it relies in good faith on an administrative rule and legal orders from a referee and the Board.

In this case, the insurer could not have relied on OAR 436-30-008(1) inasmuch as it clearly provides that the Appellate Unit has no authority to issue an amended reconsideration order after a hearing is requested. Since the Appellate Unit had no authority to issue the August 4, 1993 amended order, we do not find that this order was equivalent to the legal order of a referee or the Board. Forney is inapposite.

Finally, we note that claimant is not entitled to an attorney fee for his counsel's services on review concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated January 14, 1994 is affirmed.

In the Matter of the Compensation of
VAN L. BLOOM, Claimant
WCB Case No. C4-02276
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Schneider, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Member Neidig and Hall.

On September 6, 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 set aside the proposed disposition.

The proposed CDA contains the signatures of the insurer's claims adjuster, the insurer's attorney and claimant's attorney, but does not include claimant's signature. On the line provided for claimant's signature, his counsel signed "on behalf of" claimant. Furthermore, claimant's attorney signed on behalf of claimant on the "Notice To Claimant Per OAR 436-60-145."

At the time the CDA was first submitted to the Board, claimant's attorney also submitted an affidavit with the CDA stating that claimant had reviewed the CDA in its entirety, but that claimant was presently incapacitated. Thus, claimant's attorney stated that he had signed the CDA pursuant to claimant's attorney retainer agreement, which was also submitted with the CDA.

Subsequent to our receipt of the CDA, on September 16, 1994, the SAIF Corporation sent a letter addressed to the Board, asserting that claimant had died prior to the submission of the CDA, and that claimant had no known statutory beneficiaries under workers' compensation law. On September 27, 1994, we received claimant's response to SAIF's letter. Claimant contends that the retainer fee agreement provides the authority for counsel to sign necessary documents on claimant's behalf. Claimant also argues that, if the retainer agreement does not provide such authority, a beneficiary's signature should be requested pursuant to ORS 656.218, which provides for death benefits to be paid to statutory beneficiaries. We address both contentions in Footnote 1.[1] For the reasons expressed below, we find the agreement unreasonable.

We will not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of the existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any and all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and conditions prescribed by the Director." In accordance with this statutory mandate, the Director's rules permit such dispositions subject to the terms and conditions of OAR 436-60-145 and Division 09 of the Board's rules. OAR 436-60-145(1).

The Board's rules define a "claim disposition agreement" as a written agreement executed by all parties in which a claimant agrees to release rights or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. OAR 438-09-001(1). In other words, the Board's rules require a CDA to be executed by all parties. See OAR 438-09-001(1); Catherine E. Evans, 45 Van Natta 1043 (1993); Edgar C. Sixberry, 43 Van Natta 335 (1991).

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[1] There has been no documentation submitted regarding any "Power of Attorney" agreement executed between claimant and his attorney, nor has claimant's attorney represented that he is acting under such authority. Claimant argues that ORS 656.218 permits a beneficiary to pursue approval of the proposed agreement and to sign the agreement. ORS 656.218(5) specifically designates those entitled to pursue the claim as those defined/entitled to receive death benefits (i.e., the worker's spouse and children as provided in ORS 656.204 and ORS 656.208). Here, however, there has been no disagreement with SAIF's representation that claimant was not married and had no minor children at the time of his death. Accordingly, there is no person qualified under ORS 656.218 to pursue approval of the agreement.

Accordingly, because the original CDA does not contain claimant's original signature, it is not in compliance with the Director and Board rules. See OAR 436-60-145(1); OAR 438-09-001(1). Consequently, we disapprove the agreement as unreasonable as a matter of law. See ORS 656.236(1)(a). We recognize that the retainer agreement purports to authorize claimant's counsel to sign for claimant. Nevertheless, such an authorization cannot relieve a party from compliance with the express statutory and regulatory requirements. We consider this approach to be particularly appropriate where, as here, the record is devoid of a signature from claimant evidencing his understanding regarding the finality and significance of a CDA. Catherine E. Evans, supra (retainer fee agreement/attorney's signature not accepted as substitute for claimant's missing signature, especially where record did not show that the claimant understood the effects of the parties' CDA).[2]

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

IT IS SO ORDERED.

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[2] Claimant concedes that, if the Evans case has established an "ironclad rule," it supports SAIF's position. Claimant argues that the present case is distinguishable, as Evans involved an attorney who could not contact the client, but in this case, claimant saw the CDA and required notice, and when signing other documents, overlooked the CDA and notice.

We do not find a meaningful distinction in such facts, as both cases involve a record devoid of claimant's signature on the CDA or on any other documents discussing the finality or effect of a CDA. As in Evans, we decline to accept a retainer agreement as a substitute for claimant's signature on the CDA, and in this case, the accompanying notice provision.

In the Matter of the Compensation of
WILLIAM PACEY, Claimant
Own Motion No. 94-0432M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left shoulder, arm and wrist injury. Claimant's aggravation rights expired on February 8, 1983. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

On June 14, 1994, Dr. Warren, claimant's treating orthopedic surgeon, requested authorization to perform left ulnar nerve transposition, open endoscopic left carpal tunnel release, and left rotator cuff repair. Thus we conclude that claimant's compensable condition worsened requiring surgery by June 14, 1994, which is the time of disability.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, 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.

In the Matter of the Compensation of
LEE R. JONES, Claimant
WCB Case No. 92-05254
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to its August 4, 1994 order, the court has remanded for reconsideration of our prior order that affirmed a Referee's order that affirmed a Director's order finding claimant not eligible for further vocational assistance. Specifically, the court has remanded in light of Colclasure v. Washington County School District No. 48-J, 317 Or 526 (1993).

FINDINGS OF FACT

Claimant, 53 years old at hearing, sustained compensable right and left knee and low back injuries while working for the insured as a journeyman meatcutter in August 1985. At that time, claimant was earning $9.58 an hour.

Following his compensable injury, claimant returned to work for the insured in 1986. He was again taken off work in September 1988. At that time, claimant was earning $10.50 an hour.

Pursuant to a February 1990 stipulation, claimant's scheduled permanent disability award for the left knee was increased from 6 percent to 11 percent, and his unscheduled permanent disability award was increased from 33 percent to 38 percent. Ultimately, claimant was awarded 12 percent scheduled permanent disability for the left knee, 9 percent scheduled permanent disability for the right knee, and 42 percent unscheduled permanent disability.

Claimant was restricted to sedentary work. Consequently, as a result of vocational assistance, claimant began an on-the-job Authorized Training Program (ATP) as a locksmith in December 1990. In April 1991, the trainer terminated the ATP due to lack of work.

The insurer transferred claimant's case to another vocational counselor. Claimant attended Adult Basic Education classes to improve his 6th grade-level reading and spelling skills, and 4th grade-level math skills. In September 1991, the counselor identified a janitorial supervisor ATP with Portland Habilitation Center (PHC). The insurer indicated that it was not interested in the ATP because there were not enough janitorial opportunities for a worker with claimant's physical limitations.

Claimant received no time loss benefits after the April 1991 termination of the ATP. In light of his financial situation, claimant wanted to attempt a janitorial job with PHC, even though it only paid a starting wage of $6.35 an hour, with $7.05 an hour after three months.

In October 1991, claimant's case was transferred to a third vocational counselor. Dr. Martens, one of claimant's treating Kaiser physicians, approved a light janitorial job with PHC, as long as claimant performed no excessive squatting, kneeling, climbing, or lifting. Because the PHC job was "well beyond the physical capacities indicated by Dr. Tilson [another of claimant's treating Kaiser physicians] in terms of standing and walking," the counselor arranged a one-week on-the-job evaluation. Dr. Martens concurred in a physical therapist's evaluation that claimant was capable of performing medium level work with restrictions.

Claimant began the janitorial job with PHC on November 13, 1991. After one month, claimant's back pain increased. Claimant's supervisor assigned him light duty jobs. However, because PHC was experiencing a shortage of workers, claimant instead had to do extra work. On January 16, 1992, claimant's vocational counselor closed his vocational file as "successfully employed in suitable employment since 11/13/91."

In February 1992, claimant's Kaiser physicians took him off work and scheduled back surgery. Claimant requested further vocational assistance; the insurer refused. Claimant requested Director review of the insurer's decision.

On March 6, 1992, the Director found that claimant had successfully worked as a janitor for more than 60 days for PHC. The Director reasoned that "[w]hile this work does not pay the wages [claimant] earned at the time of his injury, it is physically suitable, and appears appropriate." The Director concluded that "[claimant]'s current employment is suitable." Therefore, apparently relying on OAR 436-120-050(2), the Director concluded that claimant was "not eligible for further vocational assistance" and, thus, the insurer was not required to provide further vocational assistance.

Claimant appealed the Director's order to the Hearings Division. A full evidentiary hearing was held.

The Referee made no independent findings of facts. Reasoning that the scope of review of a Director's order is limited, the Referee declined to address claimant's assertions that neither the wage nor the physical demands of the janitorial job were "suitable." Finding no violation of ORS 656.283(2), the Referee affirmed the Director's order.

CONCLUSIONS OF LAW AND OPINION

In our March 31, 1993 order, we affirmed and adopted the Referee's order. Claimant petitioned the Court of Appeals for judicial review of our decision. The court has remanded for reconsideration in light of Colclasure v. Washington County School Dist. No. 48-J, supra. In accordance with the court's mandate, we proceed with our reconsideration.

In Colclasure, the Supreme Court 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, 317 Or at 537.

In this case, the procedures conducted at the hearings level comport with this process. The parties developed a record before the Referee. On the basis of that record, the Referee concluded that the Director's decision neither violated a rule or statute nor evidenced an abuse of discretion. Upon reviewing the record developed before the Referee under ORS 656.283(2), however, we reach a different conclusion. See id.

The Director has prescribed rules to determine eligibility for and the nature and extent of vocational assistance to be provided injured workers pursuant to ORS 656.340. See OAR 436-120-001 et seq. Eligibility for vocational assistance ends when, among other conditions, the worker has been employed in suitable employment for 60 days. OAR 436-120-050(2).

"Suitable employment" is defined as employment for which the worker has the necessary physical capacities and skills; that is located within a reasonable commuting distance of the worker's residence; and that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment. ORS 656.340(6)(b)(B)(i), (ii) and (iii).

The Director's rules similarly define "suitable employment" as employment for which the worker has the necessary physical capacities and skills; and that is located within a reasonable commuting distance of the worker's residence. OAR 436-120-005(6)(a); compare, ORS 656.340(6)(b)(B)(i) and (ii). However, OAR 436-120-005(6)(a) further provides:

"(A) For the purpose of determining eligibility for vocational assistance, suitable employment includes a wage within 20 % of the wage currently being paid for employment which is the regular employment of the worker."

"(B) For the purpose of providing vocational assistance, the meaning of 'suitable employment,' also includes the objective that the employment provide a wage as close as possible to the wage currently being paid for the worker's regular employment. This wage may be considered suitable is not within 20 % of the previous wage, if the wage is as close as possible to the previous wage[.]" Compare, ORS 656.340(6)(b)(B)(iii).

Claimant contends that the janitor job was neither physically nor financially "suitable." Thus, claimant asserts that there is no evidence to support the Director's conclusion that claimant's employment was "suitable." In order to determine whether claimant is entitled to further vocational assistance, we must first determine whether the vocational assistance provided by the insurer produced "suitable employment" in claimant's case.

In deciding what constitutes "suitable employment," we look to the applicable statute(s) and rule(s). Subsections (i), (ii) and (iii) of ORS 656.340(6)(b)(B) enumerate three considerations for "suitable" work: physical capacities and skills; distance to place of employment; and a wage within 20 percent of that currently being paid for employment which was the worker's regular employment. Because the statute uses the conjunctive "and," all three elements must be satisfied before employment is "suitable."

OAR 436-120-005(6)(a) appears to set forth the same criteria. However, in contrast to ORS 656.340(6)(b)(B)(iii), OAR 436-120-005(6)(a)(B) provides that a wage that is not within 20 percent of the previous wage may be considered suitable, if the wage is as close as possible to the previous wage.

Here, the record establishes that claimant was employed full-time as a journeyman meatcutter at the time of the compensable 1985 injury. Claimant's unrebutted testimony at hearing was that as of September 1988, he was earning $10.50 an hour. There is no evidence in the record indicating that the wage currently being paid journeyman meatcutters is different from this hourly wage. Utilizing claimant's last documented wage of $10.50 an hour, it is apparent that the wage paid for the janitor job ($6.35 to $7.05 an hour) does not satisfy the "20 percent" statutory standard. Accordingly, claimant's employment as a janitor did not constitute "suitable" employment under the statute. ORS 656.340(6)(b)(B)(iii).

In reaching this decision, we note that neither the vocational counselor nor the Director made a determination that although the janitorial wage was not within 20 percent of the previous wage, it was "as close as possible to the previous wage." In any event, if they had, we would give no effect to that portion of the rule, as OAR 436-120-005(6)(a)(B) impermissibly expands on ORS 656.340, the authorizing statute.[1] See Forney v. Western States Plywood, 66 Or App 155 (1983) (In the event that there is a conflict between the administrative rule and the statute, it is the statute rather than the rule which controls). Finally, as we have found that claimant's wage was not "suitable," and inasmuch as all three factors enumerated in ORS 656.340(6)(b)(B) must be satisfied before employment is "suitable," we do not address claimant's alternative argument that the physical demands of the janitorial job were likewise not "suitable."

Given the fact that the janitor job was not "suitable" employment, we hold that the Director erred by applying OAR 436-120-050(2) to end claimant's eligibility for vocational assistance. That is, the factual situation in this case did not warrant the application of OAR 436-120-050(2). Therefore, we conclude that the Director violated ORS 656.340 by relying on OAR 436-120-050(2) to terminate

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[1] In Keith D. Kilbourne, 46 Van Natta 1837, on recon 46 Van Natta 1908 (1994), we noted that the Director has created a distinction between determining eligibility for vocational assistance, which is controlled by OAR 436-120-005(6)(a)(A), and providing vocational assistance, which is controlled by OAR 436-120-005(6)(a)(B). Kilbourne involved a determination of eligibility. The present case involves a situation in which vocational assistance was provided to claimant. Therefore, OAR 436-120-005(6)(a)(B) would appear to control. Because it was not pertinent to our decision in Kilbourne, we did not construe OAR 436-120-005(6)(a)(B) in light of ORS 656.340. We do so now.

claimant's eligibility for vocational assistance. See ORS 656.283(2)(a). Instead, we find that because claimant's customary or regular employment was that of a meatcutter, "suitable employment" for claimant is employment that produces a wage within 20 percent of that currently being paid for such employment as a permanent, full-time journeyman meatcutter. ORS 656.340(6)(b)(B)(iii).

Consequently, in modifying the Director's order and using a base wage of at least $10.50 an hour to calculate suitable employment, we find that claimant continues to have a substantial handicap to employment. Claimant was only able to secure work paying $6.35 to $7.05 an hour, which is not within 20 percent of the wage currently being paid for employment which was claimant's regular employment. Therefore, because claimant did not return to "suitable employment," his eligibility for vocational assistance has not ended; thus, claimant continues to be eligible for vocational assistance. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-004(2)(b); OAR 436-120-050(2). Accordingly, because the Director's order found that claimant was not eligible for (and the insurer was not required to provide) further vocational assistance, the order must be modified. ORS 656.283(2).

Inasmuch as this order will likely result in increased temporary disability compensation, claimant's attorney is awarded 25 percent of that increase not to exceed $3,800, payable directly to the attorney from the insurer. ORS 656.386(2); OAR 438-15-055(1); Keith D. Kilbourne, supra. This fee shall compensate claimant's counsel for services provided at hearing and on review. Claimant's counsel is also entitled to an attorney fee for services before the court. See Richard A. Colclasure, 46 Van Natta 1246, on recon 46 Van Natta 1547 (1994).

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 court level regarding his continuing eligibility for vocational assistance 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 the record and claimant's appellate brief), 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 March 31, 1993 order, we modify both the Referee's July 31, 1992 order and the Director's March 6, 1992 order to direct the insurer to continue providing claimant the vocational assistance he would receive based on the wage currently being paid for claimant's at-injury work as a journey meatcutter, consistent with this order. The claim is remanded to the insurer for further action consistent with this order. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed $3,800, and an assessed attorney fee of $2,500, payable by the insurer directly to claimant's attorney.

IT IS SO ORDERED.

Board Member Haynes specially concurring.

The majority relies, in part, on the opinion in Kilbourne, supra, to find a distinction between cases involving determining eligibility for vocational assistance and providing vocational assistance. Although I dissented in Kilbourne and still disagree with the majority's decision in that case, I am bound to follow the principles of stare decisis. For that reason, I concur in the majority's decision in the present case.

In the Matter of the Compensation of
TERESA L. RODRIGUEZ, Claimant
WCB Case No. 93-05982
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Mongrain's order which: (1) found claimant was not entitled to temporary total disability (TTD) after being terminated by her employer; and (2) declined to assess a penalty for the employer's allegedly unreasonable failure to pay temporary partial disability at the correct rate. On review, the issues are temporary disability and penalties.

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

If a worker is terminated from employment for reasons unrelated to a compensable injury, the worker is not entitled to a resumption of TTD. See Dawes v. Summers, 118 Or App 15, 20 (1993); Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991) (TTD not available if wage loss results from other than compensable injury).

Here, claimant was terminated from her employment for failing to join the union, as required by the employer's labor contract. The employer continued to pay temporary partial disability after the termination; it does not dispute claimant's entitlement to that compensation. However, claimant contends that she is entitled to temporary total disability compensation, because she was terminated for reasons related to her compensable injury. Specifically, claimant contends that because of her compensable injury, she was placed on modified work and reduced hours, preventing her from saving the amount required for the union initiation fee and monthly dues.

After our review of the record, we find that claimant was terminated for a reason unrelated to her compensable injury. Specifically, claimant was terminated for failing to join the union. The employer's action, taken at the demand of the union, was consistent with its labor contract.

We are not persuaded by claimant's argument that the compensable injury prevented her from joining the union. Specifically, we note that claimant was required to join the union within 30 days after beginning employment. (See Ex. 11). Claimant knew of this requirement at the time of hire. She sustained a work injury two months after beginning employment. Three weeks later, the union advised her that the initiation fee and first month's dues must be paid by the end of the month. (Ex. 11). Thus, at the time of the union's first written demand for payment, claimant had already been employed over 30 days. In other words, the union fees were actually due before claimant was injured. Accordingly, we conclude that claimant has failed to prove she is entitled to TTD after October 14, 1992.

ORDER

The Referee's order dated November 26, 1993 is affirmed.

In the Matter of the Compensation of
ALLAN R. ROEDER, Claimant
WCB Case No. 93-11303
ORDER OF ABATEMENT
Galton, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Claimant requests reconsideration of our September 20, 1994 order that: (1) concluded that the SAIF Corporation's denial of claimant's neck and right arm complaints was not barred by claim or issue preclusion; (2) upheld SAIF's denial; and (3) reversed the Referee's assessment of a penalty and attorney fee.

Claimant argues that we erred in our determination of claim and issue preclusion and compensability. In addition, he contends that we failed to address his alternative argument that his medical services were compensable diagnostic services. Claimant's respondent's brief stated "Rather than repeat Claimant's reply brief, Claimant adopts and reasserts the argument Claimant made in case number 93-05356, currently pending before the Board." (Claimant's respondent's brief at 3). In case number 93-05356, without specifying which particular diagnostic services were compensable, claimant argued that "all" of the medical services were diagnostic and compensable. In determining that the prior "claim" was premature, we noted that there was no indication in the record that there was a diagnostic service dispute. Allan R. Roeder, 46 Van Natta 1671 (1994).

In order to further consider this matter, we withdraw our September 20, 1994 order. To further assist us in clarifying which services claimant is contending are compensable diagnostic services, we implement the following supplemental briefing schedule. In doing so, the parties are admonished to confine their arguments to the record in this case presently before the Board.

Claimant's opening supplemental argument must be filed within 14 days from the date of this order. The SAIF Corporation's supplemental response must be filed within 14 days from the date or mailing of claimant's opening supplemental brief. Claimant's supplemental reply must be filed within 14 days from the date of mailing of SAIF's brief. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIANNE L. SHERIDAN, Claimant
WCB Case No. 91-09220
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Sheridan v. Johnson Creek Market, 127 Or App 259 (1994). The court has reversed our prior order, Marianne L. Sheridan, 45 Van Natta 394 (1993), which had affirmed the Referee's order upholding the insurer's partial denial of claimant's current right elbow condition. The court has reversed and remanded for reconsideration in light of United Airlines, Inc. v. Brown, 127 Or App 253 (1994).

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer accepted a claim filed for a chipped bone in claimant's elbow. After claimant received surgery to remove a loose particle in the elbow, the claim was closed by Notice of Closure on December 14, 1990. On June 7, 1991, claimant requested reconsideration of the closure notice, contending that the claim had been prematurely closed. On July 2, 1991, the insurer issued a denial of the compensability of and responsibility for claimant's elbow condition on the grounds that the compensable injury was not the major contributing cause of claimant's condition after November 26, 1990.

On July 9, 1991, an Order on Reconsideration issued rescinding the Notice of Closure, finding that it had been prematurely issued. On July 11, 1991, claimant filed a request for hearing. On July 30, 1991, an order was issued by the Appellate Review Unit withdrawing the July 9, 1991 reconsideration order on the grounds that it had no jurisdiction to reconsider the insurer's Notice of Closure because of its July 2, 1991 denial. The Referee affirmed the July 30, 1991 withdrawal order and the July 2, 1991 denial of claimant's current elbow condition.

The Board affirmed the Referee's decision upholding the insurer's denial of claimant's current elbow condition. Marianne L. Sheridan, supra. We also concluded that the purported withdrawal of the July 9, 1991 reconsideration order was an amendment of the reconsideration order which effectively affirmed the Notice of Closure. We still held that the July 9, 1991 Order on Reconsideration was invalid because claimant challenged the impairment findings and no medical arbiter was appointed as required by ORS 656.268(7).

The court held that the Appellate Review Unit had no authority to issue its July 30, 1991 order withdrawing its July 9, 1991 reconsideration order. Sheridan v. Johnson Creek Market, supra. Therefore, the July 30, 1991 order was a nullity. Inasmuch as the July 9, 1991 reconsideration order remained in effect, the court determined that the December 1990 closure notice was prematurely issued.

Finally, the court noted that the insurer's July 1991 denial had relied on ORS 656.005(7)(a)(B). Citing United Airlines, Inc. v. Brown (which held that ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim), the court instructed us to reconsider our order in light of that case. In accordance with the court's mandate, we now proceed with our reconsideration.

When the insurer issued its July 2, 1991 denial of claimant's current elbow condition, the claim had been already closed. However, as a result of the court's subsequent decision in Sheridan, that closure has been determined to have been premature. Inasmuch as there has been no valid closure of claimant's compensable injury claim, the July 2, 1991 denial is a preclosure denial of claimant's current elbow condition. We must then determine whether the denial is valid under the rationale of Brown v. United Airlines, Inc., supra.

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 condition or disease, "the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment," 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.

We recently upheld a preclosure denial and distinguished Brown in Zora A. Ransom, 46 Van Natta 1287 (1994). There, the employer issued a denial of the claimant's current low back strain condition two days prior to the claim closure. The medical evidence from the claimant's attending physician "unequivocally" indicated that the claimant's current low back strain condition was not related to the accepted low back strain. In addition, the employer's denial was not based on ORS 656.005(7)(a)(B), inasmuch as there was no preexisting low back condition that "combined with" claimant's compensable low back strain. Under those circumstances, we determined that the employer's preclosure denial did not contravene either Roller v. Weyerhaeuser Co., 67 Or App 743, rev den 297 Or 601 (1984) or United Airlines, Inc. v. Brown, supra. Zora A. Ransom, supra.

Unlike the circumstances of Ransom, however, the insurer's denial in this case was based on the presence of a preexisting elbow condition and on the terms of ORS 656.005(7)(a)(B). Moreover, unlike Ransom, the medical evidence in this case does not unequivocally establish that claimant's current elbow condition is not related to the compensable elbow condition. Claimant's current attending physician, Dr. Berselli, has opined that claimant's current elbow condition is still related to the original compensable injury in July 1990. Dr. Wade, her former attending physician, on the other hand, has opined that claimant's current condition is due in major part to a preexisting loose body condition in the right elbow. Given the difference in the medical opinions, the evidence is far from unequivocal that claimant's current elbow condition is unrelated to the elbow condition resulting from the compensable 1990 injury.

Therefore, we find Ransom distinguishable. Inasmuch as the insurer's current "resultant" condition denial issued while the claim was in open status (by virtue of the court's decision in Sheridan v. Johnson Creek Market, supra), the denial constitutes an impermissable "pre-closure" denial of an accepted claim. Sheridan v. Johnson Creek Market, supra; United Airlines, Inc. v. Brown, supra. Accordingly, we set aside the insurer's denial and reverse the Referee's decision on this issue.

Claimant has finally prevailed after remand with respect to the insurer's partial denial of her current elbow condition. 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 regarding 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 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 March 3, 1993 order, the Referee's order dated December 23, 1991 is reversed. The insurer's denial is set aside. The claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded a $4,000 attorney fee, payable by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS R. YON, JR., Claimant
WCB Case No. 94-01229
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of those portions of Referee Mongrain's order that: (1) held that the Hearings Division has jurisdiction to resolve disputes concerning proposed medical treatment; (2) set aside the insurer's denial of claimant's right hand surgery claim; and (3) awarded claimant's counsel an attorney fee pursuant to ORS 656.386(1). On review, the issues are jurisdiction, compensability of medical services, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee found that inasmuch as no party had sought review of this medical services dispute by the Department, the Hearing Division has jurisdiction. See Jefferson v. Sam's Cafe, 123 Or App 464 (1993); Meyers v. Darigold, Inc., 123 Or App 217 (1993). On review, the insurer argues that, notwithstanding Jefferson v. Sam's Cafe and Meyers v. Darigold, original jurisdiction over medical services disputes (of proposed treatment or otherwise) lies solely with the Director.

Subsequent to the Referee's decision in this case, the Supreme Court held that the Board has jurisdiction to consider a claimant's request for a hearing regarding proposed medical treatment. Martin v. City of Albany, 320 Or 175 (1994). Thus, the Hearings Division and the Board have jurisdiction to consider this medical services dispute.

Compensability/Surgery

We adopt the Referee's reasoning and conclusion that neurolysis surgery is reasonable and necessary treatment for claimant's compensable right hand crush injury.

Attorney Fees

The Referee awarded claimant an assessed attorney fee for prevailing over the insurer's medical services denial. See ORS 656.386(1); Gwen Jackson, 46 Van Natta 357, on recon 46 Van Natta 822 (1994). Relying on SAIF v. Allen, 123 Or App 383 (1993), the insurer argues that no assessed fee is payable where the insurer denies proposed medical treatment but does not deny compensability of the injury claim itself.

Subsequent to the Referee's order in this case, the Supreme Court reversed the Court of Appeals' decision in Allen. SAIF v. Allen, 320 Or 192 (1994). Finding that a claim for medical services is a "claim for compensation" within the meaning of ORS 656.386(1) and the definitions in ORS 656.005(6) and (8), the Court held that ORS 656.386(1) allows an award of attorney fees when an employer or insurer denies a claim for medical services, but does not deny the compensability of the claimant's injury or condition. Accordingly, claimant's attorney is entitled to a reasonable assessed fee for prevailing at hearing over the insurer's medical services denial.

In the event a fee is payable, the insurer contends that the amount awarded by the Referee should be reduced. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree that a reasonable fee for claimant's counsel's services at hearing is $2,500, as awarded by the Referee. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

In addition, claimant's attorney is entitled to a reasonable assessed fee for services on review concerning the medical services issue. ORS 656.382(2). After considering the same factors as set forth above, we find that a reasonable fee for claimant's counsel's services on review is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated. No attorney fee is available for that portion of claimant's brief devoted to the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated May 4, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,200, to be paid directly by the insurer to claimant's counsel.

In the Matter of the Compensation of
THEO HEINTZ, Claimant
WCB Case No. 93-13081
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Garaventa's order which: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) declined to award interim compensation from August 16, 1993 until the insurer's September 7, 1993 denial. On review, the issues are compensability and interim compensation.

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

Compensability

Claimant contends the Referee erred in requiring claimant to introduce expert medical evidence to prove causation, citing Uris v. Compensation Department, 247 Or 420 (1967). See also Barnett v. SAIF, 122 Or App 279 (1993) (expert medical evidence not required where the claimant suffered immediate pain, promptly reported injury and sought medical treatment within 24 hours). While claimant apparently experienced immediate symptoms after shoveling gravel on August 17, 1993 and testified that he promptly reported his injury to the employer, we agree with the Referee that the causation issue is complex, thus requiring expert medical evidence for its resolution.

Claimant testified that he requested permission from the employer to seek chiropractic care the morning after his alleged injury. The employer testified that he didn't recall this aspect of their conversation. However, even if claimant testified truthfully, the fact remains that claimant did not seek or receive medical treatment until a week after the alleged injury. For this reason, we find this claim distinguishable from Barnett, supra. Moreover, there was credible testimony from witness Rhodes that claimant was not physically impaired the evening of the alleged date of injury. (Tr. 46). This testimony casts doubt on whether claimant sustained a significant injury as he alleged.

Under the above circumstances, we agree with the Referee that claimant was required to produce expert medical evidence to establish that he sustained a compensable injury on August 17, 1993. We also agree for the reasons cited in the Referee's order that the medical opinion of the only physician to address causation, Dr. Stewart, is insufficient to satisfy claimant's burden of proof.

Interim Compensation

ORS 656.262(4)(a) requires the insurer to begin payment of interim compensation "no later than the 14th day after the subject employer had notice or knowledge of the claim." A claim "means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). "Knowledge of an injury" should include enough facts as to lead a reasonable employer to conclude that worker's compensation liability is a possibility and that further investigation is appropriate. See Argonaut Ins. Co. v. Mock, 95 Or App 1, 5 (1989); David Hernandez, 46 Van Natta 423 (1994).

Here, claimant contends that the employer had notice or knowledge of a "claim" when he reported an injury on August 17, 1993. Claimant asserts that, inasmuch as he sustained a loss of earning power as a result of the alleged injury, he is therefore entitled to interim compensation from August 17, 1993 to the date of the insurer's denial on September 7, 1993. We disagree.

Claimant testified that he reported an injury to Pat Dean, the president of the employer's company, and that he had requested a claim form. Dean was aware of claimant's back pain, but testified that claimant did not appear injured and did not request a claim form. Dean also testified that she laid off claimant the day after the alleged injury. However, the Referee found that, based on their demeanor and the substance of their testimony, claimant and Dean were unreliable witnesses with respect to portions of their testimony.

Assuming, without deciding, that the employer had sufficient knowledge of an injury such that it should have concluded that workers' compensation liability was a possibility, there is still no evidence that claimant suffered a loss of earnings as a result of the alleged injury. See RSG Forest Products v. Jensen, 127 Or App 247, 251 (1994) (Where the claimant "left work" and suffered a loss of earnings as a result of an injury, he was entitled to interim compensation even though he was fired for reasons unrelated to the injury). Therefore, we conclude that claimant is not entitled to interim compensation for the period prior to the insurer's denial.

Claimant testified that he has not worked since the alleged injury on August 17, 1993. However, the record suggests that claimant did not leave work due to the compensable injury in light of Dean's testimony that claimant was laid off. Furthermore, while the fact that claimant was laid off, allegedly for reasons unrelated to his injury, does not necessarily preclude him from receiving interim compensation, RSG Forest Products v. Jensen, supra, no physician authorized time loss or imposed work restrictions on claimant prior to the September 7, 1993 denial. Although claimant was advised on September 13, 1993 to avoid heavy lifting and was released to modified work on January 4, 1994, there is no evidence that these work restrictions had been in effect prior to September 7, 1993. Cf. Jerilyn Hendrickson, 46 Van Natta 1888 (1994) (Where work restrictions placed on the claimant prior to denial resulted in diminished earning power, the claimant was entitled to interim compensation even though fired for reasons unrelated to injury). In light of such evidence, we are unable to conclude that claimant suffered a loss of earnings related to his alleged injury prior to the insurer's denial. RSG Forest Products v. Jensen, supra. Claimant is, therefore, not entitled to interim compensation.

ORDER

The Referee's order dated February 25, 1994 is affirmed.

In the Matter of the Compensation of
LARRY L. SCHUTTE, Claimant
WCB Case No. 92-15997
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee T. Lavere Johnson's order which awarded claimant permanent total disability effective November 8, 1989. On review, the issue is permanent total disability (unscheduled and scheduled permanent disability if claimant is not permanently and totally disabled). We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also offer the following summary of the relevant facts.

Claimant compensably injured his low back on October 9, 1980 while employed as a button station operator for a forest products manufacturing business. Dr. Whitney has been claimant's attending physician since 1980. He performed a fusion at L5-S1 in 1981 and a refusion and extension of the fusion from L4 to the sacrum in 1983. The claim was first closed on July 27, 1984 by Determination Order which awarded 20 percent unscheduled permanent disability. Claimant has received a total of 75 percent unscheduled permanent disability.

In 1987, claimant was placed in a vocational training program at Fletcher's Automotives. On June 30, 1988, claimant experienced an aggravation of his back pain while working at Fletcher's. The claim was reopened for the aggravation claim in August 1988 and reclosed by Determination Order on January 26, 1990. No additional permanent disability was awarded.

Additional surgery was recommended in May 1990 before a hearing could be held regarding claimant's appeal of the January 26, 1990 Determination Order. The request for surgery was treated as a request for reopening of the 1980 claim. Since claimant's aggravation rights had expired on July 27, 1989, the employer treated the matter as arising under the Board's "own motion" authority. See ORS 656.278. On July 18, 1990, the Board deferred action on the employer's own motion referral, pending the outcome of litigation on the compensability of the proposed surgery as well as other issues. The request for surgery was apparently not pursued by claimant, who was placed in a training program at Mast Brothers with the goal of being a dispatcher, tow-truck driver and shop estimator.

On May 31, 1991, claimant had a flare-up of his back condition due to his work activities at Mast Brothers. Dr. Whitney requested authorization for an L3-4 discectomy and refusion at L4-5. The employer authorized the surgery which was performed on December 11, 1991.

The 1991 surgery request was once again treated as an aggravation of the 1980 injury and referred to the Board for action under its own motion authority. Time loss was paid to claimant pending resolution of litigation to determine whether the May 1991 worsening was an aggravation or a new injury. The Board placed the own motion request in deferred status pending the results of litigation. A referee determined that the May 1991 worsening was an aggravation of the 1980 injury rather than a new injury. This finding was affirmed by the Board in Larry L. Schutte, 45 Van Natta 2085 (1993). There is no indication in the record that the May 1991 aggravation claim resulted in reopening of the 1980 injury claim under the Board's own motion authority.

Claimant has not returned to regular work or been involved in a successful job search or training program since his employment at Mast Brothers. Claimant was 40 years old at hearing with a formal 12th grade education. However, he is functionally illiterate and also has dyslexia that affects his ability to read and write. He also demonstrates a third grade reading, fourth grade language and a fourth grade math level. Claimant's physical capacity for employment is in the sedentary to light range.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was permanently and totally disabled under the "odd-lot" doctrine effective November 8, 1989. See Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985). This was the date claimant became medically stationary for purposes of the January 26, 1990 Determination Order, the closure which is at issue in these proceedings. Specifically, the Referee interpreted the vocational evidence as establishing that, in the absence of a vocational training program, claimant was not employable in the competitive labor market on a regular basis. The Referee accordingly concluded that there was presently no suitable and gainful occupation which claimant was capable of regularly performing. See ORS 656.206(1)(a).

In order to establish permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Welch v. Bannister Pipeline, supra; 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 he or 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, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

In this case, there is no dispute as to whether the "odd-lot" analysis applies. Nor is there a dispute about whether claimant is willing to work or whether reasonable efforts have been made to find employment. The employer challenges the Referee's award of permanent total disability on the grounds that the Referee erred in considering claimant's condition resulting from the May 1991 worsening because claimant's aggravation rights expired on July 27, 1989. The employer asserts that the rating of claimant's permanent disability should be limited to the period prior to the May 1991 "own motion" aggravation.

The Referee determined that he had jurisdiction to rate claimant's permanent disability but did not directly address the employer's contention that claimant's permanent disability should be evaluated as of May 1991 rather than at the time of the hearing in March 1993. See Gettman v. SAIF, 289 Or App 609 (1980). However, the Referee found that claimant had proved permanent disability status on November 8, 1989, when claimant became medically stationary for purposes of the January 26, 1990 Determination Order. The Referee reasoned that claimant's physical, mental, educational and vocational status had not substantially changed since that date. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370 (1983) (PTD award is effective as of the earliest date that all elements necessary to the claim existed).

Generally, a determination of permanent total disability must be made based on conditions at the time of hearing. See Gettman v. SAIF, supra; Ronald L. Bartlett, 45 Van Natta 948, 949 (1993). However, even if we were precluded from considering claimant's condition after the May 1991 aggravation claim, we would still agree with the Referee's determination that claimant had proved permanent total disability status prior to the "own motion" aggravation claim.

Dr. Whitney, claimant's treating physician, released claimant to light to sedentary employment in July 1990, shortly after the claim closure in January 1990. (Ex. 58). Claimant was completely precluded from bending, crawling and kneeling and limited to intermittent climbing, squatting and balancing. In addition, claimant was also limited to walking no more than 5 hours in a day and no more than 1 hour at one time. Claimant's sitting was limited to 4 hours a day and no more than 1 hour at a time.

On December 7, 1992, after claimant became medically stationary from his "own motion" aggravation claim, Dr. Whitney again addressed claimant's work restrictions. (Ex. 107). Dr. Whitney again released claimant for sedentary to light work and commented that claimant's work restrictions were similar to those already present. Based on his observation of the employer's surveillance film, Dr. Whitney decreased claimant's limitation on overall standing/walking from 5 hours to 6 hours. He also decreased claimant's limitation on walking at one time from 1 hour to 2 hours. Claimant's other restrictions were the same or quite similar to those in July 1990.

Based on a comparison of claimant's work restrictions both before and after the May 1991 worsening, claimant's physical capabilities have remained relatively constant despite his testimony that his physical condition was worse after the May 1991 aggravation and subsequent surgery, and despite some reduction in range of motion after the aggravation in May 1991.

The employer cites the physical capacities evaluations of Mr. Ross, a vocational rehabilitation consultant and work capacity evaluator, as demonstrating that claimant's physical capacities declined significantly after the May 1991 aggravation claim. Mr. Ross' testing on January 29, 1991 revealed that claimant could lift 22 pounds from the floor, 12 pounds from the waist and 15 pounds from the shoulder, whereas his testing in October 1992 and March 1993 showed a significant reduction in lifting capability to less than the full range of sedentary work. (Tr. 97).

While Mr. Ross's testing resulted in physical limitations more significant than those found by Dr. Whitney, Mr. Ross did not disagree with Dr. Whitney's work restrictions. In fact, Mr. Ross utilized Dr. Whitney's work restrictions while attempting to identify potential employers for claimant. (Tr. 112). Moreover, Mr. Ross testified that his testing confirmed Dr. Whitney's work restrictions and was "compatible" with them. (Tr. 113).

In light of this testimony, we do not find that Mr. Ross' physical capacities testing establishes that claimant's physical capabilities significantly decreased as a result of the May 1991 aggravation claim. Therefore, the Referee's failure to differentiate between claimant's condition before and after the May 1991 aggravation claim was not an error, assuming, without deciding, that the rating of claimant's permanent disability should be confined to the period prior to the "own motion" aggravation.

Finally, the employer contends that claimant had sufficient transferable skills to be employable without training prior to the own motion aggravation claim and needed only brief on-the-job training after he became medically stationary relative to the own motion aggravation. Therefore, the employer asserts that claimant was not permanently and totally disabled prior to or after the May 1991 aggravation. However, we agree with the Referee that the vocational evidence establishes that claimant is permanently and totally disabled. This is regardless of whether claimant's vocational circumstances are considered before May 1991 or thereafter.

Three vocational counselors testified at the hearing. Ms. Ridley-Hartgrave provided vocational services from July 1990 through June of 1991, which includes the period prior to the "own motion" aggravation claim. She testified that claimant had sufficient transferable skills so that he could have performed gainful employment without training. (Tr. 141). She identified several jobs that she felt could perform within his work restrictions and testified that his employment options would be aided by his qualification for preferred worker assistance. (Trs. 141-147).

However, the Referee determined that Ms. Ridley-Hartgrave's testimony was unreliable and that she was unresponsive and possibly evasive on cross-examination. Thus, the Referee discounted Ms. Ridley-Hartgrave's testimony. To the extent that the Referee's credibility finding was based on her manner of testifying, we defer to that assessment on review. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Moreover, based on our review of the substance of Ms. Ridley-Hartgrave's testimony, we do not find her opinion to be very persuasive.

Ms. Ridley-Hartgrave testified on cross-examination that she did not perform any job analyses for the positions that she testified that claimant could have performed in June 1991 and that the jobs were merely "potentials." (Tr. 158). She conceded that additional follow-up would have been necessary to determine whether claimant could have performed the identified positions. (Trs. 159, 164). In the absence of performing job analyses, Ms. Ridley-Hartgrave could not identify any employers that would have hired claimant. (Tr. 164).

Mr. Cardinal, who provided vocational services to claimant from July 1992 through the day of the hearing, also testified that claimant had a variety of unskilled job opportunities that claimant would have qualified for without a formal training program. (Tr. II-29, 30). However, Mr. Cardinal admitted that, given claimant's vocational circumstances, he could not name an employer who would likely hire claimant without a training program. (Tr. 72). Mr. Cardinal also testified that claimant did not have a preferred worker's card and that, even if he did, he would still need training and accommodation by

an employer before it could be determined that job placement was successful. (Trs. 79, 80.) Like the Referee, we interpret Mr. Cardinal's testimony as indicating that claimant is not employable on a regular basis in the general labor market without a training program. The employer's contention notwithstanding, we find that this training would require more than the usual period of orientation normally required in any job, whether skilled or unskilled.

Our conclusion that claimant requires additional training before he will become competitively employable is further reinforced by the testimony of Mr. Ross, who was hired by claimant to evaluate his employability. (Tr. 89). He opined that, based on Dr. Whitney's work restrictions, as substantiated by his testing, and claimant's "severe" reading and learning disability, claimant was not currently employable in the competitive labor market. (Tr. 102). Mr. Ross subsequently clarified that claimant could be employable, but only with additional vocational training. (Trs. 104, 110).

In conclusion, we find that the vocational evidence does not establish that claimant is presently capable of regularly performing work at a gainful and suitable occupation. See ORS 656.206(1)(a). This is true regardless of whether claimant's permanent disability is rated before or after the May 1991 aggravation. Inasmuch as we agree with the Referee that claimant's medical, social and vocational status has not changed significantly since the November 8, 1989 medically stationary date, we further concur that claimant's permanent total disability status is established as of that date. See Arva M. Perkins, 42 Van Natta 2384, 2387 (1991).

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 counsel's services on review is $1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 30, 1993 is affirmed. For services on review, claimant's counsel is awarded $1,500, to be paid by the employer.

Board Member Haynes specially concurring.

I agree with the majority that, based on this record, claimant is permanently and totally disabled. I write separately, however, because of my reluctance to declare a 40 year-old permanently and totally disabled under the "odd-lot" doctrine, when he still has sedentary to light employment capabilities.

I consider claimant's permanent total disability status to be primarily the result of a failure of vocational rehabilitation. As the Referee pointed out, claimant has been provided vocational services since 1985, yet, despite claimant's "full cooperation," he has not returned to work. The fault, unfortunately, appears to lie with the vocational counselors working with claimant both before and after the "own motion" aggravation claim. While finding suitable employment for claimant may be difficult considering his physical limitations, it is certainly far from impossible.

I would urge the employer in the strongest terms possible to insure that claimant receives retraining and successful job placement in the next two years so that, when claimant is reevaluated in two years pursuant to ORS 656.206(5), he will not be found permanently and totally disabled once again.

Because I believe that a finding of permanent total disability could have been avoided with better vocational rehabilitation services, I must specially concur.

In the Matter of the Compensation of
FRANCIS A. SIMS III, Claimant
WCB Case Nos. 93-02067 & 92-15231
ORDER ON RECONSIDERATION
Jon C. Correll, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney
Meyers, Radler, et al., Defense Attorneys

Lumbermen's Underwriting Alliance (LUA) requested reconsideration of our August 3, 1994 Order on Review. Specifically, LUA requested clarification of the attorney fee awards assessed against LUA. On September 1, 1994, we withdrew our August 3, 1994 order in order to consider LUA's motion.

By letter dated September 26, 1994, LUA's attorney stated that LUA and claimant had reached an "accord regarding interpretation of the [Board's] alternative penalty and attorney fee assessed against LUA for unreasonable processing." Furthermore, he stated that claimant and LUA "would be agreeable to an Order on Reconsideration which republishes the Order on Review." By letter dated October 3, 1994, claimant's attorney agreed with LUA's representations.

In light of the parties' representations, we republish our August 3, 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 R. ZIMBELMAN, Deceased, Claimant
WCB Case Nos. 93-02973 & 93-02972
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

The self-insured employer has requested reconsideration of our September 22, 1994 Order on Review. Specifically, the employer contends that we erred in affirming that portion of the Referee's order that set aside its denial of claimant's claim for a fatal myocardial infarction. After considering the employer's motion and memorandum in support, we issue the following order.

The employer first contends that claimant has not established that his myocardial infarction occurred in the course and scope of employment. We agree with the employer's contention to the extent that the myocardial infarction was not caused directly by an on-the-job event or exposure. However, claimant does not seek to establish his myocardial infarction as an independent compensable event. Rather, he contends that it is compensable as a consequence of his compensable injury. Therefore this matter is properly analyzed under ORS 656.005(7)(a)(A).

Here, we agree with the Referee that the persuasive medical evidence establishes that claimant's myocardial infarction was caused, in major part, by his emotional upset over his inability to work, his pain, and his reaction to the employer's processing of his claim, including the disputed temporary disability check. All of these factors are sequelae of claimant's compensable injuries.[1]

Under ORS 656.005(7)(a)(A), a secondary consequential condition is compensable if claimant establishes that the compensable injury, including injury-related sequelae, is the major cause of the consequential condition. See Albert H. Olson, 46 Van Natta 1848 (1994)(Consequential psychological condition compensable where evidence establishes that condition is caused, in major part, by job loss, loss of self esteem, feelings of worthlessness and failure, all of which are related to compensable injury).

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[1] Contrary to the employer's argument, the Referee correctly considered both of claimant's compensable injuries; i.e., the cervical condition and the carpal tunnel syndrome, in determining whether the compensable injuries were the major contributing cause of claimant's myocardial infarction. See Kepford v. Weyerhaeuser Co., 77 Or App 363, 366, rev den 300 Or 722 (1986).

As noted above, claimant has established that his compensable injuries and their sequelae were the major contributing cause of his myocardial infarction. Therefore, we continue to find that claimant's myocardial infarction is compensable. Olson, supra.

Accordingly, our September 22, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

Board Member Haynes specially concurring.

On review, the employer relied on SAIF v. Hukari, 113 Or App 475 (1992) and argued that claimant's myocardial infarction was not compensable on the basis that claimant had not established a compensable occupational disease under 656.802. As our previous order indicated, that decision is no longer controlling in light of the Supreme Court's decision in Mathel v. Josephine County, 319 Or 235 (1994).

On reconsideration, the employer now focuses on whether claimant has established a compensable consequential condition under ORS 656.005(7)(a)(A). While I agree with Chair Neidig's dissent in Albert H. Olson, supra, and would not consider the "sequelae" of the compensable injury in analyzing this matter under ORS 656.005(7)(a)(A), I am nevertheless bound by the doctrine of stare decisis to agree with the result in this case.

October 14, 1994 Cite as 46 Van Natta 2195 (1994)

In the Matter of the Compensation of
ANA J. CALLES, Claimant
WCB Case No. 93-12389
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Referee Hazelett's order directing SAIF to pay claimant's attorneys the fee portion of temporary disability compensation previously paid to claimant. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

In July 1992, claimant entered into a retainer agreement in which she agreed to pay her attorneys an approved fee out of any disability compensation awarded by Determination Order. (Ex. 1). The retainer agreement also provided for direct payment of the approved fee to claimant's attorneys for deposit in a trust account pending approval of the fee by the Hearings Division.

Thereafter, a September 4, 1992 Determination Order reclassified claimant's injury claim as disabling. That Determination Order included a copy notation which listed claimant's attorney by name. (Ex. 2).

On September 21, 1992, claimant filed a hearing request seeking an approved fee out of the temporary disability compensation paid pursuant to the reclassification. (Ex. 3). The hearing request was signed by claimant's attorney. On or around September 18, 1992, SAIF received a copy of the hearing request.

SAIF commenced payment of temporary disability benefits on December 7, 1992. (Ex. 7). SAIF did not withhold or pay any amount of the benefits to claimant's attorneys as an approved fee. SAIF took this action even though it knew that claimant had filed the hearing request and was represented by counsel.

On March 5, 1993, claimant and SAIF entered into a stipulation providing for an approved fee payable out of any temporary disability compensation paid as a result of the claim reclassification. Specifically, the stipulation provided that claimant's attorney "shall receive" an "out-of-compensation" attorney fee from "any time loss allowed as a result of the reclassification of the claim" and "from any permanent disability allowed as a result of the reclassification." Finally, the stipulation provided that the attorney fees would be payable "through and including the first Notice of Closure or Determination Order."

Following the stipulation, SAIF continued to pay temporary disability benefits to claimant without withholding or paying any amount to claimant's attorneys as an approved fee. On October 19, 1993, claimant requested a hearing seeking payment of the stipulated fee from SAIF.

CONCLUSIONS OF LAW AND OPINION

The Referee ordered SAIF to pay claimant's attorneys the fee portion of the temporary disability compensation paid after the September 4, 1992 Determination Order. On review, SAIF contends that it has no obligation to pay the fee because the compensation has already been paid to claimant. In the alternative, SAIF contends that it should only pay a fee out of temporary disability compensation awarded after the March 5, 1993 stipulation.

We begin our analysis with a review of the Board's decision in Nancy E. O'Neal, 45 Van Natta 1490, on recon 45 Van Natta 1591, on recon 45 Van Natta 2081 (1993). In O'Neal, the claimant filed a supplemental hearing request raising an issue regarding the rate at which SAIF had paid temporary disability compensation. Prior to the hearing, SAIF recalculated the claimant's award and paid the claimant the disputed amount. It did so without contacting the claimant's attorney or paying the attorney a fee out of the increased compensation.

SAIF took this action even though it was aware of claimant's hearing request and an executed retainer agreement providing for an approved fee payable out of temporary disability compensation obtained by claimant's counsel. The O'Neal Board concluded that, in this particular situation, it was not inequitable to require SAIF to pay the approved fee. Thus, the Board ordered the carrier to pay the fee directly to the claimant's attorney and recover the resulting overpayment against any future permanent disability awards.

In reaching its conclusion, the O'Neal Board relied on the fact that the claimant's attorney could not have taken any other action to secure receipt of the fee, and SAIF knew that the claimant was represented by counsel when it paid out the entire award. On this basis, the Board distinguished its decision in O'Neal from prior orders in which it required the claimant's attorney to look to the claimant for recovery of a fee payable out of previously paid compensation. See Gabriel M. Gonzales, 44 Van Natta 2399 (1992); Carol J. Paxton, 43 Van Natta 1846 (1991); Kenneth V. Hambrick, 43 Van Natta 1636 (1991); Mohammad Zarifi, 42 Van Natta 670 (1990).

Subsequent to its decision in O'Neal, the Board issued its order in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994). In Volk, the Board refused to order the self-insured employer to pay the claimant's attorney the fee portion of a permanent disability award paid out prior to litigation. The employer in Volk had paid the permanent disability award pursuant to a Determination Order. On reconsideration, the award was reduced, and the claimant requested a hearing. The parties then entered into a stipulation which reinstated the Determination Order award.

The Volk Board concluded that the claimant's attorney was entitled to an "out-of-compensation" fee for the reinstatement of the permanent disability award. However, relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the Board further concluded that it would be creating an improper overpayment if it ordered the employer to pay the fee. Therefore, the Board delineated an alternative method for recovery of the attorney fee from claimant, rather than the employer.

Following its order in Volk, the Board issued its decision in Davey L. Odle, 46 Van Natta 776 (1994). The facts in Odle were similar to those in O'Neal, supra. Citing its prior ruling in O'Neal, the Board ordered the carrier to pay claimant's attorney the fee portion of additional temporary disability benefits paid out after a request for hearing seeking payment of those benefits. Accord Skip W. Ivie, 46 Van Natta 198 (1994).

In reaching its decision, the Odle Board noted that the carrier had, essentially, created an overpayment of temporary disability by its unilateral action of paying out the total amount of a temporary disability award to the claimant. On this basis, the Odle Board distinguished its decision in that case from its prior holding in Volk, where the overpayment in question would have been created by the Board, rather than the carrier.

We analyze the facts of the present case in light of the Board's decisions in O'Neal, Volk and Odle. Based on the following reasoning, we conclude that SAIF is obligated to pay the approved fee directly to claimant's attorney.

Prior to that stipulation, claimant's attorneys had taken all reasonable precautions to secure the approved fee. They had obtained a retainer agreement authorizing direct payment of the fee to the attorneys for deposit in a trust account, and they had requested a hearing seeking approval of the fee.

Despite these precautions, SAIF paid temporary disability benefits without withholding or paying any amount to claimant's attorney as an approved fee. SAIF took this action even though it knew that claimant had retained counsel and had filed a hearing request to secure an approved fee.

As a result of its unilateral action, SAIF essentially created an overpayment of temporary disability compensation. Under these circumstances, it is not inequitable to require SAIF to pay claimant's attorneys the fee portion of the compensation paid prior to the March 5, 1993 stipulation. See Davey L. Odle, supra; Nancy E. O'Neal, supra.

We reach a similar conclusion regarding the fee portion of the compensation paid after the stipulation. The fully executed and approved stipulation did not expressly require SAIF to withhold or direct payment of the approved fee directly to claimant's attorneys. Nevertheless, the stipulation specifically provided that claimant's attorney "shall receive" an "out-of-compensation" attorney fee from "any time loss allowed as a result of the reclassification of the claim" and "from any permanent disability allowed as a result of the reclassification." Finally, the stipulation provided that the attorney fees would be payable "through and including the first Notice of Closure or Determination Order."

As in Mohammad Zarifi, supra, the prior referee's order (in this case the stipulation) does not explicitly direct the carrier to pay the "out-of-compensation" attorney fee directly to claimant's counsel. However, considering the circumstances existing at the time of the settlement resolving this "classification" dispute (i.e., SAIF's unilateral payment of temporary disability to claimant with knowledge of her representation), we are persuaded that the references to "out-of-compensation" attorney fees in the stipulation demonstrated an understanding that SAIF would pay such fees directly to claimant's counsel until the maximum limits were satisfied or the first claim closure, whichever came first.

Consequently, as with the "pre-March 5, 1993" temporary disability, we consider it equitable to require SAIF to pay claimant's attorneys the fee portion of the temporary disability compensation paid after the March 5, 1993 stipulation. In reaching this conclusion, we distinguish Gerald Billings, 43 Van Natta 399 (1991), where we declined to direct a carrier to reimburse the claimant's attorney for an attorney fee payable from previously paid compensation. In Billings, we reasoned that the claimant's attorney had failed to include language in an "Own Motion-TTD" stipulation providing for payment of an "out-of-compensation" fee directly to the attorney. Here, in contrast to Billings, claimant's attorney did include language in the stipulation which we find sufficient to secure claimant's attorney's right to an "out-of-compensation" fee payable directly to claimant's attorney.

In summary, we conclude that SAIF must pay claimant's attorneys the fee portion of the temporary disability compensation paid prior to and subsequent to the March 5, 1993 stipulation. SAIF may recover this attorney fee payment from future permanent disability awards under this claim. See Nancy E. O'Neal supra.

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 February 14, 1994 is affirmed.

In the Matter of the Compensation of
MERRY E. FRANKLIN, Claimant
WCB Case No. 92-14761
SECOND ORDER ON RECONSIDERATION
Willner & Heiling, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our August 12, 1994 Order on Reconsideration which: (1) directed SAIF to provide vocational assistance to claimant; and (2) awarded claimant's counsel an "out-of-compensation" attorney fee. Contending that we erred in calculating claimant's "base wage" for purposes of determining her eligibility for vocational assistance, SAIF seeks remand for further development of the record. In addition, SAIF requests clarification of our "out-of-compensation" attorney fee award.

In order to further consider this matter, we withdrew our August 12, 1994 order. Claimant's response has been received and we, therefore, proceed with our reconsideration.

SAIF first contends that we should remand this matter for evidence concerning the wage "currently being paid" for professional, long-distance bus drivers. See OAR 436-120-005(6)(a)(A).

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).

Here, SAIF has not established that unidentified evidence that it seeks to introduce was unobtainable with due diligence at the time of hearing. Moreover, other than SAIF's conclusory assertion that the current wage for claimant's "at-injury" job is much less than her "at-injury" wage, there is nothing in the record to rebut the evidence that claimant's "at-injury" wage accurately represents the current wage being paid for such an occupation. In other words, we find the record as presently developed sufficient to conduct our review.

SAIF next contends that our order erred in finding that claimant was limited to work paying minimum wage. SAIF argues that, although the Director's order used the minimum wage as claimant's base wage, the Director did not find that claimant was capable of performing only work paying minimum wage. SAIF contends that there are other jobs that claimant is capable of performing that pay more than minimum wage, and therefore, the case should be remanded to the Referee to admit additional evidence on the issue.

We again find no compelling reason to remand this matter to the Referee. The Director found that $4.75 (minimum wage) was a suitable wage for claimant. At hearing, the parties submitted the matter to the Referee on the record and SAIF took the position that the Director's order should be affirmed. In other words, SAIF raised no objection to the Director's "minimum wage as a suitable wage" finding. In light of such circumstances, we are not inclined to find that the "evidence" which SAIF now seeks to introduce was unobtainable with due diligence at the hearing. Moreover, the jobs suggested by SAIF are again based on speculation, which does not establish that the outcome of this case would be changed if we were to remand.

Additionally, even if we were to consider SAIF's argument that claimant is capable of performing a job that pays $8.50 per hour, such a wage equals only $340 per week, which is not within 20 percent of the $630 per week we have found represents the current wage being paid for claimant's "at-injury" Greyhound bus driving job. Accordingly, even under such an analysis, claimant would still have a substantial handicap to employment and would be entitled to vocational assistance.

Finally, SAIF requests clarification of our attorney fee award, which provided for an approved attorney fee for claimant's counsel of 25 percent of the increased compensation created by our order. Our order is hereby clarified to provide for an "out-of-compensation" fee of 25 percent of the increased temporary disability benefits arising from our decision, not to exceed $3,800, payable directly to claimant's attorney from SAIF. See Keith D. Kilbourne, 46 Van Natta 1837 (1994); on recon 46 Van Natta 1908 (1994).

Accordingly, we withdraw our August 12, 1994 order. On reconsideration, as supplemented and clarified herein, we republish our August 12, 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
SUSAN K. MARLNEE, Claimant
WCB Case No. 93-12153
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Hoffman, et al., Defense Attorneys

On September 20, 1994, we reduced claimant's scheduled permanent disability award for loss of use or function of the left forearm (wrist) from 28 percent (42 degrees), as awarded by a Referee's order, to 24 percent (36 degrees), as awarded by an Order on Reconsideration. In addition, we affirmed the Referee's attorney fee award under ORS 656.382(2) because the self-insured employer had unsuccessfully attempted at hearing to reduce or disallow the compensation granted by the Order on Reconsideration.

The employer has moved for reconsideration of our decision. Asserting that we erroneously relied on the findings made by the medical arbiter (Dr. Gehling) rather than those made by the attending physician, the employer contends that claimant is not entitled to a permanent disability award.

To begin, we disagree with the employer's characterization of our decision as providing "no explanation" for our reliance on Dr. Gehling's impairment findings. To the contrary, on the paragraph beginning at the bottom of page 2 and ending at the top of page 3 of our decision, we explain why we found Dr. Gehling's examination to constitute a thorough and accurate evaluation of her impairment.

In any event, when compared with the testing and findings contained in Dr. Layman's July 1993 "Progress Notes," we find Dr. Gehling's report regarding claimant's range of motion findings, sensory loss tests, and grip strength determinations to be more thorough and well-reasoned.[1] Consequently, we rely on Dr. Gehling's findings as more persuasive than Dr. Layman's in evaluating claimant's permanent impairment.

Accordingly, we withdraw our September 20, 1994 order. On reconsideration, as supplemented herein, we republish our September 20, 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] The employer further contends that Dr. Layman "found nothing upon which to grant a permanent disability award." In December 1992, Dr. Layman did check a box which indicated that claimant had suffered "no permanent impairment." (Ex. 15). Furthermore, in July 1993, Dr. Layman reported that several range of motion, strength and sensory loss tests were either normal or negative. (Ex. 23). Nevertheless, in that same July 1993 "Progress Note", Dr. Layman also noted some positive sensory loss findings, paresthesias complaints in claimant's fingers, and reduced grip strength/key pinch in claimant's left hand. (Ex. 23-3). Finally, Dr. Layman expressed no specific opinion concerning the extent, if any, of claimant's permanent impairment. Rather, Dr. Layman recommended that claimant "continue on splinting, and we'll see her back in one month to assess her progress." (Ex. 23-3, 4).

In light of such circumstances, we do not share the employer's interpretation that Dr. Layman's July 1993 report supports a conclusion that claimant did not suffer permanent impairment as a result of her compensable condition. In fact, if anything, some of Dr. Layman's findings provide some initial confirmation for Dr. Gehling's eventual conclusions regarding claimant's permanent impairment.

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case Nos. 92-16492 & 93-01866
THIRD ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On August 22, 1994, we issued an Order on Reconsideration rejecting the self-insured employer's argument that it was entitled to offset temporary disability it paid pursuant to the Department's Order on Reconsideration to the date of the hearing, against additional permanent disability awarded by the Order on Review. On September 20, 1994, we issued a Second Order on Reconsideration adhering to the conclusion reached in the first Order on Reconsideration. Both orders were issued in response to the employer's motions.

Claimant now moves for abatement and reconsideration, asserting that he is entitled to an assessed attorney fee pursuant to ORS 656.382(2) for services concerning the employer's motions for reconsideration.[1] The employer opposes the motion on the ground that, inasmuch as its requests for reconsideration pertained only to the issue of offset, there was no threat of reduction or disallowance to claimant's compensation.

Pursuant to the Department's Order on Reconsideration rescinding a Determination Order, the employer paid temporary disability before the hearing in this proceeding. Our Order on Review found that there was no premature claim closure and reversed the Department's Order on Reconsideration. However, on reconsideration, based on ORS 656.313(2), we found that the employer was not entitled to an offset for temporary disability it paid before a hearing pursuant to the Department's Order on Reconsideration.

An offset for overpayment against future compensation is not considered a threat to the award of compensation since the offset only allows the employer to recover the amount that claimant was not entitled to receive. Strazi v. SAIF, 109 Or App 105, 108 (1991). In view of our conclusion that there was no premature claim closure, and because the employer's motions for reconsideration addressed only the issue of offset, we conclude that the employer's motions did not threaten the "award of compensation" and, therefore, claimant's attorney is not entitled to an award under ORS 656.382(2) for services on reconsideration. Id.

We withdraw our September 20, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our September 20, 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] We received claimant's response to the employer's second motion for reconsideration on September 23, 1994, three days after issuance of our September 20, 1994 Second Order on Reconsideration. Therefore, inasmuch as we did not consider claimant's response in issuing the Second Order on Reconsideration, claimant would not be entitled to an attorney fee for any services devoted to that response. See Shirley M. Brown, 40 Van Natta 879 (1988).

In the Matter of the Compensation of
TAMARA FORD, Claimant
WCB Case No. C4-02248
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coughlin, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Member Haynes and Gunn.

On August 31, 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, and add the following concerning a revision in the Department of Consumer and Business Services's (Department) rules.

Former OAR 436-60-145(4)(e) stated:

"The claim disposition agreement shall also contain, but not be limited to, the following: The worker's age, highest education level, and the extent of vocational training."

Effective August 28, 1994, the Department issued WCD Admin. Order 94-055, revising OAR 436-60-145. OAR 436-60-145(4)(e) now states in pertinent part:

"The claim disposition agreement shall also contain, but not be limited to, the following: The worker's age, highest education level, and the extent of vocational training, including a list of occupations * * *. (Emphasis added)."

Thus, the revised rule requires two items concerning a claimant's vocation: the extent of training and a list of occupations claimant has held. OAR 436-60-145(4)(e).

Here, the CDA states in part:

"The worker has been trained to perform the following vocation(s): Waterproofer, grocery checker, production manager, and grocery clerk." (P.2, ln. 23-24)."

We note that, although the CDA lists the vocations in which claimant has been trained, it does not indicate whether claimant has worked in those occupations and/or other occupations. Accordingly, a CDA providing such language would not be in compliance with the Department's new rule. Nevertheless, because this CDA contains at least one signature from a party dated before the Director's rules became effective, we find that the CDA in this instance is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved. An attorney fee of $375, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH B. CANTRELL, Claimant
WCB Case No. C4-02262
ORDER CORRECTING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Member Neidig and Hall.

On October 7, 1994, the Board approved the parties' claims disposition agreement (CDA) in the above captioned matter. It has subsequently come to our attention that the order contained a clerical error. Specifically, on page one, the heading recites incorrect information as to the WCB case number, claim number, date of injury, WCD file number, and claimant's social security number.

Accordingly, to correct this clerical error, we issue this order correcting the approved claims disposition agreement, with the correct information regarding claimant's claim now contained in the heading of this order.

IT IS SO ORDERED.

October 14, 1994 Cite as 46 Van Natta 2202 (1994)

In the Matter of the Compensation of
LARRY W. GANGE, Claimant
WCB Case Nos. 90-21432 & 90-15533
ORDER ON RECONSIDERATION
Estell & Bewley, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys

EBI Companies requests reconsideration of our September 15, 1994 Order on Remand, which found that EBI failed to prove a "new compensable injury" under ORS 656.308(1) and SAIF v. Drews, 318 Or 1 (1993), and, thus, responsibility for claimant's low back condition remained with EBI rather than shifting to the SAIF Corporation. EBI raises several arguments challenging the Order on Remand.

EBI first requests that we remand the case to the Referee to admit additional evidence regarding the opinion of the treating physician, Dr. Lewis. According to EBI, "fairness and substantial justice" requires such action because Dr. Lewis' initial opinion was solicited at a time when the law required only a showing that "claimant had suffered a new injury which was the material contributing cause of his disability and need for treatment" and the Board found Dr. Lewis' opinion to be inconsistent.

We rejected a similar argument in Rosalie S. Drews, 46 Van Natta 408 (1994) (Order on Remand). There, although acknowledging that there was no caselaw interpreting ORS 656.308(1) at the time of hearing, we found no compelling reason for remanding when the record contained medical evidence regarding the causal relationship between the claimant's condition and her employments. Id. at 410. The record in this case similarly contains medical evidence of causation, including opinions from Dr. Lewis and Dr. Short. Therefore, we conclude that there is no compelling reason to remand and we deny EBI's motion. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

EBI further contends that we "confused the facts in this case" by stating that EBI and SAIF denied responsibility and by failing to indicate that SAIF also had denied compensability at the time of hearing. We first note that the "Findings of Fact" from our Order on Review stated that "SAIF denied both compensability and responsibility for claimant's low back condition" and "EBI denied responsibility only." Because the Order on Remand republished such findings, the order also factually found that SAIF denied compensability and responsibility at the time of hearing. However, because the "Conclusions of Law and Opinion" portion of the Order on Remand indicated that "[b]oth EBI and SAIF denied responsibility," we provide the following findings to clarify any possible inconsistency.

"At the time of hearing, SAIF had denied compensability and responsibility while EBI had denied only responsibility."

EBI also asserts that the Board, on remand from the court, should have found that claimant sustained a "new compensable injury" under ORS 656.308(1) and shifted responsibility to SAIF. In so contending, EBI relies on claimant's testimony at hearing and Dr. Lewis' opinion.

Because this case concerns an evaluation of the relative contribution of a number of potential causes for claimant's low back condition, we find it to be a complex case. See Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). Therefore, although claimant's testimony is probative, we primarily rely on expert medical evidence. Id. With regard to the evaluation of the medical evidence in the Order on Remand, we continue to adhere to the discussion finding Dr. Lewis' opinion not reliable. Therefore, we continue to conclude that claimant did not sustain a "new compensable injury" pursuant to ORS 656.308(1) and responsibility remains with EBI. See SAIF v. Drews, supra.

EBI next argues that, because SAIF withdrew its denial of compensability on appeal, it conceded that claimant did sustain a "new injury" and, thus, is precluded from denying responsibility. We find no merit to EBI's contention. Assuming, for the sake of argument, that SAIF conceded that claimant's low back condition was compensable, it continued to challenge responsibility on appeal. In other words, SAIF has not conceded that the evidence satisfies EBI's burden of proof in establishing that claimant sustained a "new compensable injury" while working for SAIF's insured, thereby shifting responsibility for claimant's low back condition to SAIF under ORS 656.308(1).

Finally, EBI asserts that, because only SAIF put claimant's right to compensation at risk by denying compensability, SAIF should be liable for the assessment of attorney fees. Although both insurers initially denied compensability and responsibility, by the time of hearing only SAIF continued to contest the compensability of claimant's low back condition. Under such circumstances, there is precedent to support a conclusion that the nonresponsible insurer could be liable for an attorney fee awarded under ORS 656.386(1). Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, on recon 119 Or App 447 (1993).

Nevertheless, in the present case, EBI did not raise the attorney fee objection until issuance of our Order on Remand. Inasmuch as EBI did not present the "Referee attorney fee award" issue in its appellate briefs to the Board, we decline to consider the issue at this late date. Kenneth D. Nichols, 45 Van Natta 1729 (1993) (Board will not address new issues for the first time on reconsideration).

Since our prior order set aside SAIF's denial and found SAIF responsible for claimant's attorney fee award, it is understandable that EBI would not raise the "Board review attorney fee" award before the court. Therefore, we shall consider that attorney fee issue.

Because SAIF had denied compensability at the time of the hearing, claimant's compensation remained at risk on review. See Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). However, since EBI requested Board review and we did not reduce or disallow claimant's compensation, we continue to find EBI responsible for the assessed attorney fee awards for services on review. See ORS 656.382(2); Cigna Insurance Companies v. Crawford and Co., supra; William J. Emery, 45 Van Natta 1521, on recon 45 Van Natta 1777 (1993).

Accordingly, we withdraw our September 15, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our September 15, 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
AUDREY L. CASEY, Claimant
WCB Case No. 93-09911
ORDER ON REVIEW
Gary D. Taylor, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brown's order that found that claimant's left pes planus (flat foot) condition was not "de facto" denied but was part of the accepted low back claim. On review, the issues are scope of acceptance and compensability. We reverse.

FINDINGS OF FACT

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

Prior to the claim acceptance, claimant suffered from a L5-S1 herniated disc, with left S1 radiculopathy.

On February 12, 1992, the insurer issued a "Notice of Claim Acceptance" that accepted the claim as disabling and listed the accepted condition as "ruptured disc L5-S1." (Ex. 21).

On April 27, 1992, Dr. Saviers, treating M.D., diagnosed a flattened right [sic, should be left] foot secondary to "weakness of the foot intrinsic and extrinsic muscles that are innervated by the left S1 nerve root." (Ex. 28).

On November 11, 1993, claimant was examined by Dr. Rich, neurologist, and Dr. Potter, orthopedist, on behalf of the insurer. (Ex. 68A).

We add the following ultimate findings of fact. The compensable L5-S1 herniated disc is the major contributing cause of the subsequently developed left pes planus (flat foot) condition. The left pes planus condition was not included in the insurer's February 12, 1992 acceptance.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer accepted the left pes planus condition when it accepted the herniated disc at L5-S1 because "the pes planus condition is a description of the pathology that results when the nerves innervating the muscles to the foot are damaged." (Opinion and Order, page 2). We disagree that the left pes planus condition was included in the insurer's acceptance of "ruptured disc L5-S1." However, we find that the pes planus condition is a compensable consequential condition.

We find that the left pes planus condition was not included in the insurer's February 12, 1992 acceptance. 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). Whether acceptance of a claim has occurred is a question of fact. SAIF v. Tull, 113 Or App 449 (1993).

Here, the insurer specifically accepted "ruptured disc L5-S1." (Ex. 21). Thus, the specific language of the acceptance does not include any pes planus condition. In fact, claimant did not develop a pes planus condition until several months after the the insurer issued its acceptance, although claimant suffered from radiculopathy into the left lower extremity as a result of the herniated disc from the time she first sought medical treatment. On April 27, 1992, Dr. Saviers, treating M.D., opined that claimant had developed a flattened right [sic, should be left] foot secondary to "weakness of the foot intrinsic and extrinsic muscles that are innervated by the left S1 nerve root." (Ex. 28).

Citing Georgia Pacific v. Piwowar, 305 Or 494 (1988), the insurer argues that claimant's left pes planus condition is part of the accepted ruptured disc condition. We disagree. Piwowar, supra, holds that, where a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom. However, here, the insurer did not accept a symptom of a disease. Instead, it accepted a "ruptured disc L5-S1," which is a specific condition. Although, as discussed below, the ruptured disc and the resulting denervation of the S1 nerve root caused the subsequent pes planus condition, the ruptured disc is not a symptom of the pes planus condition. Accordingly, we conclude that the insurer's February 12, 1992 acceptance did not include claimant's left pes planus condition.

A physician's report requesting medical treatment for a specified condition constitutes a claim that must be accepted or denied within the statutory time limit or it is deemed "de facto" denied. Safeway Stores, Inc. v. Smith, 117 Or App (1992); Barr v. EBI Companies, 88 Or App 132 (1987). Here, by a report dated April 27, 1992, which the insurer received on May 7, 1992, Dr. Saviers requested medical treatment for claimant's pes planus condition. (Ex. 28). The insurer had not previously accepted the pes planus condition, and Dr. Saviers' April 27, 1992 report constituted a claim. Furthermore, the insurer did not accept or deny that claim within 90 days of notice or knowledge of the claim. Therefore, we find that a "de facto" denial occurred. Safeway Stores, Inc. v. Smith, supra; Barr v. EBI Companies, supra.

As to compensability, claimant argues that her left pes planus condition arose as a result of the compensable disc condition and, as such, comes under ORS 656.005(7)(a)(A). We agree. Because claimant's pes planus condition did not arise directly from her work injury, the pes planus 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 pes planus condition, claimant must prove that the original low back condition is the major contributing cause of the current pes planus condition. Kephart v. Green River Lumber, 118 Or App 76 (1993); Albany General Hospital v. Gasperino, supra.

Dr. Saviers opined that claimant has a left pes planus condition, the major contributing cause of which is the compensable L5-S1 disc herniation, which resulted in denervation and weakness in the muscles that support the arch. (Exs. 28, 68, 70).

The only other medical opinion is from Dr. Rich, neurologist, and Dr. Potter, orthopedist, who examined claimant on behalf of the insurer. (Ex. 68A). Responding to a question regarding the cause of claimant's flat foot condition, they opined that they were "not particularly impressed that [claimant] has a fallen arch." (Ex. 68A-5).

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. Saviers. He has treated claimant since she initially sought treatment for her compensable back condition in November 1991. Furthermore, he persuasively explains why claimant has a flat left foot in comparison to the right foot. (Exs. 28, 68-3, 70). Accordingly, on this record, claimant has established compensability of her left pes planus condition.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate 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 February 17, 1994 is reversed. The insurer's "de facto" denial of the left pes planus condition is set aside, and the claim is remanded to it for processing according to law. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $2,500, payable by the insurer.

October 17, 1994 Cite as 46 Van Natta 2205 (1994)

In the Matter of the Compensation of
DONALD L. MARTIN, Claimant
WCB Case No. 92-10346
ORDER ON REMAND
Emmons, Kropp, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Martin, 129 Or App 314 (1994). On reconsideration of its prior opinion, 127 Or App 739 (1994), the court modified its decision which had vacated a Board order that had affirmed a Referee's order directing the self-insured employer to reprocess claimant's claim. Since the Board had awarded an attorney fee under ORS 656.382(2) for services on Board review concerning this claim processing issue, the employer had sought elimination of the attorney fee award. Noting that the Board had also awarded an attorney fee for services on review pertaining to the referee's denial of the employer's motion to dismiss claimant's hearing request, the court has remanded for reconsideration of the attorney fee award.

Consequently, on remand, we must determine whether claimant is entitled to an attorney fee solely for services on Board review concerning the employer's request for review of the Referee's denial of its motion to dismiss claimant's hearing request. Based on the following reasoning, we conclude that claimant is not entitled to an attorney fee award for his counsel's services on Board review.

Claimant is entitled to a carrier-paid attorney fee when the carrier initiates review or appeal, and the Board or court finds that "the compensation awarded to a claimant should not be disallowed or reduced." ORS 656.382(2). Here, because the court vacated that portion of the Referee's order which directed the employer to reprocess claimant's claim, no compensation has been awarded to claimant.

Thus, prevailing on the employer's motion to dismiss claimant's hearing request does not in itself result in an award of compensation to claimant. Therefore, claimant is not entitled to an attorney fee award under ORS 656.382(2).

Accordingly, on reconsideration of the attorney fee portion of our July 9, 1993 order, we vacate the attorney fee award in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELVA M. McBRIDE, Claimant
WCB Case No. 93-07257
ORDER ON RECONSIDERATION
Bryant, Emerson, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our August 8, 1994 Order on Review that concluded that claimant has established the compensability of medical services related to her accepted low back condition following the November 1992 "off work" motor vehicle accident. On August 31, 1994, we abated our order to further consider the employer's request and provide claimant an opportunity to respond to the employer's motion. Having received claimant's response and the employer's reply, we proceed with our reconsideration.

The employer contends that we improperly characterized the issue on review as a medical services dispute because the only dispute was whether claimant's current low back condition "remained" compensable following the November 21, 1992 off-the-job motor vehicle accident. The employer argues that the claim is not compensable because her compensable injury is not the major contributing cause of her current low back condition. Alternatively, the employer requests that we set aside its denial on procedural grounds on the basis of United Airlines, Inc. v. Brown, 127 Or App 253 (1994).

In our Order on Review, we affirmed the Referee's order which set aside the employer's May 10, 1993 partial denial with respect to claimant's low back condition. On reconsideration, we continue to adhere to that conclusion, but do so based on the following reasoning.

In United Airlines, Inc. v. Brown, supra, the court held that a carrier's preclosure "resultant condition" denial under ORS 656.005(7)(a)(B) was not procedurally valid where the claim had not first been closed. See also Sheridan v. Johnson Creek Market, 127 Or App 259 (1994) (ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim). The Brown 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. 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 Brown 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 Brown 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 John M. Lampman, 46 Van Natta 1184 (1994) (applying Brown); Jean K. Elliott-Moman, 46 Van Natta 991 (1994) (applying "preclosure denial" Brown analysis on reconsideration where Brown issued after referee's order and validity of denial continued to be challenged on review).

Here, claimant is not seeking treatment for a new injury or condition different from her accepted claim. After claimant's compensable June 1992 motor vehicle accident, she began treatment for her lumbar strain with Dr. Belza in July 1992. Dr. Belza's November 9, 1992 chart note states that claimant had not shown any improvement with the standing body cast and facet blocks. (Ex. 1B). He noted that any form of activity, no matter how minor, exacerbated her symptoms. (Id.) Dr. Belza recommended that claimant undergo vocational rehabilitation because she had not demonstrated sufficient improvement to return to her original job. Dr. Belza advised claimant to continue taking pain medication and increase her activity level.

Dr. Belza continued to treat claimant after her November 21, 1992 off-the-job motor vehicle accident. Dr. Holmboe, an orthopedic surgeon, and Dr. Mendius, a neurologist, examined claimant in January 1993 and diagnosed "[m]ild to moderate cervical and low back strain from the accident of 06-10-92" and "[r]ecurrent cervical spine strain and low back strain secondary to automobile accident of 11-21-92." (Ex. 3). Dr. Belza concurred with the opinion of Drs. Holmboe and Mendius that claimant's injuries from the November 1992 accident were superimposed on the cervical and lumbar strain sustained in the June 1992 accident. (Ex. 9). Dr. Belza also agreed that claimant's lumbar spine condition was worsened by the November 1992 accident, although he could not state whether it was merely a symptomatic worsening or a worsening of the underlying condition. (Id.)

Based on this record, we conclude that claimant's current low back condition is the same condition as the accepted low back condition. Claimant is not seeking treatment for a new injury or condition different from her accepted claim, nor does the medical evidence establish the existence of a new or different condition requiring medical treatment. See Marianne L. Sheridan, 46 Van Natta 2185 (1994) (evidence did not establish that the claimant's current elbow condition was unrelated to the compensable elbow condition). Therefore, the employer's May 10, 1993 partial denial with respect to claimant's low back condition was an invalid preclosure denial of an accepted condition and must be set aside. See Sheridan v. Johnson Creek Market, supra; United Airlines, Inc. v. Brown, supra.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration 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 response to the request for reconsideration and the employer's reply concerning the attorney fee), the complexity of the issues, and the value of the interest involved.

Accordingly, as supplemented herein, we adhere to and republish our August 8, 1994 Order on Review. For services on reconsideration, claimant's attorney is awarded an additional assessed attorney fee of $500, paid by the employer. The parties' rights of appeal shall begin to run from this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK L. NICHOLAS, Claimant
WCB Case Nos. 92-14089 & 92-09008
ORDER ON REVIEW
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant, pro se, requests review of that portion of Referee Nichols' order that upheld the insurer's denial of claimant's claim for somatoform pain disorder. With his brief, claimant submits several documents not admitted into evidence at hearing. We treat such a submission as a request for remand to the Referee. The insurer cross-requests review of that portion of the Referee's order that denied its motion to dismiss for failure to timely request a hearing. On review, the issues are dismissal, remand and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Dismissal

The insurer asserts that the Referee erred in denying its motion to dismiss on the ground of claimant's failure to timely request a hearing. We disagree.

The Referee concluded that, because there was no evidence in the record showing when claimant obtained actual or constructive knowledge of the insurer's denial, the insurer was not entitled to prevail on its defense of untimely request for hearing. Following hearing, on January 7, 1994, the insurer filed a "Motion To Reopen and Reconsider," which included a copy of a return receipt that revealed that claimant had accepted delivery of an article on August 17, 1992. The insurer argued that, because the denial had been issued on August 17, 1992, and because claimant had filed his request for hearing on October 26, 1992, more than 60 days later, see ORS 656.319(1)(a), claimant's request for hearing was untimely, thus warranting a dismissal. The Referee issued an abatement order on January 18, 1994.

Four days earlier, on January 14, 1994, claimant had filed his request for review. Accordingly, the Referee's abatement order was without legal effect. Compare Dorothy F. Knight, 45 Van Natta 1696 (1993) (abatement order given effect when issued same day as request for review filed). Because the insurer renews its dismissal argument on review, and because that argument requires us to consider evidence not in the record, we will treat the insurer's argument as a request for remand to the Referee. ORS 656.295(5); see Lester E. Saunders, 46 Van Natta 1153 (1994).

To merit remand for consideration of the return receipt, the insurer must clearly show that the evidence 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. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

The only evidence regarding the insurer's diligence in attempting to obtain the evidence is its counsel's statement in its "Motion to Reopen and Reconsider":

> "Upon receipt of Your Opinion and Order, I searched my legal file one more time and was unable to locate the return receipt which would have satisfied the points raised by you in your Opinion and Order. When I asked my client to provide a copy of the return receipt to me, with the receipt I was informed that it had been provided to Gary Allen (claimant's former counsel), then representing the Claimant, on September 22, 1992 as a piece of 'additional information' sent by the claims representative to adverse counsel on a routine basis."

The insurer's counsel evidently obtained the return receipt (or a copy) at some point thereafter.

On this record, we conclude that the insurer has failed to establish that the return receipt could not have been obtained with due diligence at the time of hearing. Specifically, the insurer offers no reason why its file could not have been searched or claimant's former counsel contacted before hearing. Furthermore, we note that the copy of the return receipt attached to the "Motion to Reopen and Reconsider" does not indicate what was sent and received. Because counsel's unsworn assertion that the receipt concerned the insurer's denial is not considered evidence, Cruz v. SAIF, 120 Or App 65 (1993), we find that there is no proof that the return receipt relates to the insurer's denial. Accordingly, we conclude that consideration of the return receipt is not reasonably likely to affect the outcome of the case. For these reasons, we deny the insurer's request for remand and affirm the Referee's denial of its request for dismissal.

Remand

Claimant submits several documents with his request for review. We treat the submission as a request for remand to the Referee for the taking of additional evidence. ORS 656.295(5); Lester E. Saunders, supra.

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 for consideration of additional evidence, the party moving for remand must clearly show that the evidence 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. See Compton v. Weyerhaeuser Co., supra; Metro Machinery Rigging v. Tallent, supra.

The documents that accompany claimant's request for review consist of an article about fibromyalgia, medical and employment records, correspondence and copies of two checks. There is no evidence suggesting that these documents were not obtainable with due diligence at the time of hearing. Furthermore, we are not convinced that, if the evidence were admitted, it would be reasonably likely to affect the outcome of the case. Accordingly, we find no compelling reason to remand to the Referee. Claimant's request for remand is therefore denied.

In reaching this conclusion, we note that we cannot review evidence that is not in the record. Furthermore, if evidence is not in the record because of poor legal representation, as alleged by claimant in this case, resolution of that issue is not for this forum.

Compensability

We adopt and affirm the Referee's conclusions regarding compensability.

ORDER

The Referee's order dated December 23, 1993 is affirmed.

In the Matter of the Compensation of
FELICITAS DELEON, Claimant
WCB Case Nos. 93-09094 & 93-06663
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

AIAC/Express Temp Service requests review of Referee Neal's order that: (1) set aside AIAC's denial of compensability and responsibility for claimant's occupational disease claim for right carpal tunnel syndrome; (2) set aside AIAC's denial of responsibility for claimant's occupational disease claim for right arm overuse syndrome; and (3) upheld CNA/Olsten Temp Service's denials of compensability and responsibility for the same conditions. AIAC moves for remand for the admission of additional medical reports which it contends are highly probative on the issue of whether claimant has any diagnosable upper extremity condition, particularly carpal tunnel syndrome. On review, the issues are remand, compensability and responsibility. We deny remand and affirm.

FINDINGS OF FACT

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

On July 9, 1993, CNA disclaimed responsibility for claimant's "current condition" and denied claimant's aggravation claim on the basis that her right carpal tunnel syndrome was not the result of her accepted condition of right arm overuse syndrome. (Ex. 22).

On July 27, 1993, AIAC disclaimed responsibility for claimant's right carpal tunnel syndrome. (Ex. 26).

On August 19 (not April 19), 1993, AIAC denied compensability of claimant's right carpal tunnel syndrome. (Ex. 29).

At hearing, AIAC clarified its disclaimer of responsibility to include claimant's right arm overuse syndrome. (Tr. 2).

CONCLUSIONS OF LAW AND OPINION

Remand

AIAC argues that this case should be remanded for admission of post-hearing medical reports from Drs. Gill and Dine, physicians who authored several reports that are already in the record. 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, the moving party must establish, inter alia, 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, 646 (1986); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still be "obtainable" at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or at 648; James E. Gore, 45 Van Natta 1652 (1993).

In March 1993, claimant saw Dr. Dine at the request of her treating physician, Dr. Fancher, for a nerve conduction study. On March 15 and 18, 1993, Dr. Dine authored reports regarding claimant's condition. On May 25, 1993, claimant saw Dr. Gill at the request of Dr. Fancher. On May 25; July 20; August 24; and September 2, 1993, Dr. Gill authored reports regarding claimant's condition.[1] These reports are in the record.

The hearing was held on March 3, 1994. AIAC did not mention an outstanding request for medical reports from Drs. Dine or Gill or request a continuance to keep the record open for the purpose of receiving reports from either physician.

Subsequent to the hearing, on March 23, 1994, claimant returned to Dr. Gill for an examination and consultation. Dr. Gill referred her to Dr. Dine for repeated nerve conduction studies. Both physicians provided AIAC with their reports. Dr. Dine's report indicated that he was unable to identify definite abnormalities. Dr. Gill's reports indicated that, although he found positive Tinel's and Phalen's signs, he no longer recommended surgical intervention for claimant's carpal tunnel condition. Instead, he released claimant to work with a splint on her right hand and limited the repetitive use of her right hand, with follow up in one month.

We are not persuaded that Dr. Gill's and Dr. Dine's reports were unobtainable with the exercise of due diligence at the time of hearing. There is no evidence that AIAC, who requested that claimant submit to an examination by Dr. Button on December 31, 1993, could not have obtained another nerve conduction study prior to hearing if it had questioned the validity of the earlier one, particularly since Dr. Button recommended that a repeat nerve conduction study be done. Moreover, AIAC did not request that the record be left open for the purpose of obtaining another study and evaluation. AIAC has offered no explanation why it failed to do so and how such an explanation would justify a remand.

Thus, although Dr. Dine's and Dr. Gill's post-hearing reports were not available at the time of hearing, we are not convinced that the substance of their opinions were not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or at 648; James E. Gore, supra.

Moreover, in light of the persuasive opinions offered by Drs. Fancher, Peterson, Snodgrass and Gill regarding the diagnosis of claimant's carpal tunnel syndrome, as well as the absence of a change in diagnosis by Dr. Gill after receiving the additional nerve conduction study, we are not convinced that consideration of Dr. Dine's and Dr. Gill's post-hearing reports would be reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., supra. For these reasons, we deny AIAC's request for remand and proceed with our review.

Compensability

On February 10, 1989, when CNA was on the risk, claimant sought treatment for right forearm, wrist and hand achiness , as well as tingling in the hand and numbness in the third and fourth digits. After being unable to elicit a Tinel's sign indicative of carpal tunnel syndrome, Dr. Fancher, claimant's attending physician, diagnosed tendinitis/overuse syndrome of the right forearm and hand. CNA

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[1] Dr. Dine's reports stated that claimant's median sensory latencies were normal, although the right was prolonged in comparison to the left. (Exs. 19 and 20). Dr. Gill opined that claimant had carpal tunnel syndrome in spite of the relatively normal nerve studies. He recommended surgery. (Ex. 21). Dr. Gill also opined, after examining and questioning claimant regarding her work and symptoms, that her work at AIAC's insured was the major contributing cause of her carpal tunnel condition and that her pregnancy and obesity were not significant factors in the development of her carpal tunnel condition in 1993. (Exs. 25, 30 and 33).

accepted claimant's claim as a right overuse syndrome.[2] On August 21, 1989, the claim was closed with no permanent disability.

In May 1992, claimant began working for AIAC's insured at a job requiring 8 to 10 hour days assembling and disassembling 40 pound disc units for computers, using both automatic and manual screwdrivers. In the fall of 1992, claimant's symptoms reappeared, including aching, numbness and tingling in her digits, forearm pain, and waking at night from the pain and numbness. Claimant was laid off work in January 1993. On February 9, 1993, claimant sought treatment for her right arm, wrist and hand symptoms. Dr. Fancher diagnosed overuse syndrome and carpal tunnel syndrome, and, although nerve conduction studies were normal, he sent claimant to Dr. Gill, orthopedist, who diagnosed right carpal tunnel syndrome and sought authorization for surgery.

On July 9, 1993, CNA denied compensability and responsibility for claimant's aggravation claim, specifically her carpal tunnel syndrome. On July 27, 1993, as amended August 19, 1993, AIAC denied compensability and responsibility for claimant's new occupational disease claim for carpal tunnel syndrome. At hearing, AIAC also denied responsibility for claimant's overuse syndrome.

Claimant's current condition has been diagnosed as both a right overuse syndrome and a right carpal tunnel syndrome. The Referee held that both syndromes are compensable occupational diseases that are the responsibility of AIAC.

Relying on Dr. Button's opinion, AIAC contends that claimant's carpal tunnel syndrome does not exist, or, if it does exist, it is not work-related.[3] Specifically, AIAC contends that a diagnosis of carpal tunnel is suspect absent definitive nerve conduction verification and that claimant's credibility is compromised by the histories claimant provided to her doctors.

We adopt the Referee's conclusion and reasoning regarding the compensability of claimant's right carpal tunnel syndrome with the following supplementation to address the arguments on review.

First, the lack of a definitive diagnosis does not per se defeat a claim. Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). Nevertheless, the persuasive medical evidence relied upon by Drs. Gill, Snodgrass and Peterson indicates that claimant's current condition includes objective symptoms of carpal tunnel syndrome, including tingling in the second, third and fourth digits of her right hand and nocturnal pain and numbness in the right hand that woke her at night and which required medical services. Moreover, positive Tinel's and Phalen's tests performed by these doctors revealed median nerve involvement. See ORS 656.802(1) and (2); Suzanne Robertson, 43 Van Natta 1505 (1991) ("Objective findings" include symptoms for which a claimant is seeking treatment).

Second, after our de novo review of the record, we find no conflict in claimant's histories as provided to Drs. Fancher and Gill. The more detailed history claimant provided to Dr. Gill was in response to specific questioning regarding the details of her work and its correlation with her symptoms. Moreover, the history given to Dr. Gill corresponds with the history claimant provided at hearing. Consequently, we have no reason to doubt claimant's credibility. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) (In exercising de novo review, we may make a credibility assessment based upon our evaluation of the substance of a witness' testimony).

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[2] There is no formal acceptance in the record. However, in its denial, CNA stated, "This letter is also to advise you that based on the medical information we have in our file, your carpal tunnel syndrome is not the result of your accepted condition of right arm overuse syndrome." (Ex. 22). In 1989, although claimant complained of tingling and numbness in the fingers of her right hand, Dr. Fancher ruled out carpal tunnel syndrome. Moreover, Drs. Snodgrass and Case, who examined claimant for CNA, also noted aching, tingling and numbness of the fingers of the right hand but diagnosed only overuse syndrome of the right forearm after finding both Tinel's and Phalen's tests to be negative. (Ex. 9-4). Based on the contemporary medical evidence, we conclude that CNA's acceptance was limited to claimant's right arm overuse syndrome. See SAIF v. Tull, 113 Or App 449 (1992) (Whether an acceptance occurs is an issue of fact).

[3] On review, AIAC does not contend that claimant's right arm overuse syndrome is not compensable.

In addition, we are more persuaded by the opinions of Drs. Gill, Snodgrass and Peterson that claimant's work activities, not her 1989 pregnancy and ongoing obesity, are the major contributing cause of her carpal tunnel condition than Dr. Button's opinion to the contrary. (Compare Exs. 21-2 and 24-6 with 36-4). We discount Dr. Button's opinion because his history that claimant gained 100 pounds as a result of her pregnancy was flawed and his analysis of the intensity of claimant's work activities was based on a generalized conclusion from having observed videotapes of similar work (but not of claimant or her actual work activities) at some time in the past. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Responsibility

The Referee concluded that AIAC is responsible for claimant's right overuse syndrome and right carpal tunnel syndrome. AIAC first contends that claimant's current condition is merely an exacerbation of the 1989 claim and that there has been no pathologic worsening of her condition. Alternatively, AIAC contends that work activities at its insured had no impact on the development or worsening of claimant's current condition.

We again note that claimant has two conditions, a right arm overuse syndrome, and a right carpal tunnel syndrome. Because only the overuse syndrome is an accepted condition, we analyze responsibility separately for each condition.

Overuse Syndrome

Our first inquiry is whether this condition is governed by ORS 656.308(1). To answer that question, we must determine whether the right overuse syndrome for which claimant currently seeks compensation involves the "same condition" as the condition CNA accepted in 1989. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). We conclude that it does.

Claimant's testimony and the medical evidence support our conclusion. After claimant's 1989 claim was closed, she continued to have minimal pain symptoms for which she self-medicated with Tylenol. Her pain worsened somewhat when she used her right arm to operate a wheelchair ramp and when she trimmed plastic parts at subsequent employments. Her symptoms improved on weekends and when her workload was changed. However, claimant's ongoing symptoms did cause her to seek medical treatment for her right arm until 1992, when Drs. Fancher, Snodgrass and Peterson diagnosed recurrent overuse syndrome in the right forearm and hand, based on claimant's history of recurrent symptoms. (Exs. 16, 17, 24, 28 and 32). We conclude that claimant's current condition is the "same condition" as her 1989 overuse syndrome condition. Accordingly, ORS 656.308(1) applies.

Because the onset of claimant's overuse syndrome developed gradually, we analyze it as a new occupational disease claim. Valtinson v. SAIF, 56 Or App 184, 187 (1982). ORS 656.308 encompasses occupational diseases. Liberty Northwest v. Senters, 119 Or App 314 (1993). To establish a "new occupational disease" following the closure of its accepted claim, CNA has the burden of establishing that the claimant's work activities at AIAC's insured were the major contributing cause of the claimant's current right arm overuse condition. See ORS 656.802(2); Steven K. Bailey, 45 Van Natta 2114, 2116 (1993); see also SAIF v. Drews , 318 Or 1 (1993).

Drs. Snodgrass and Fancher addressed the cause of claimant's current right arm overuse condition.[4] Dr. Snodgrass, who examined claimant on behalf of CNA, opined that claimant's work activities at AIAC's insured were the major contributing cause of her worsened condition. He based his opinion on the fact that claimant's condition after claim closure in 1989, and prior to her work activities at AIAC's insured, had improved to the point that she was able to work at various jobs using her right arm, whereas she has experienced a substantial increase in symptoms since her 1993 employment. Dr. Snodgrass' opinion is supported by the record, which shows no medical treatment for claimant's right arm during this period. Moreover, Dr. Snodgrass indicated that the symptoms of claimant's overuse syndrome were the condition, with the severity of the symptoms dependent on the severity of the condition.

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[4] Dr. Button also addressed the cause of claimant's right overuse syndrome. We do not find his opinion persuasive, given his doubts about the diagnosis of overuse syndrome ("an all-inclusive, wastebasket type of terminology to perhaps fit within the guidelines of nonspecific, subjective complaints") and his insistence that claimant had no objective findings of an organic condition in 1989 or thereafter. See Kuhn v. SAIF, 73 Or App 768 (1985) (Medical opinion contrary to the "law of the case" is not persuasive).

We find Dr. Snodgrass' opinion more persuasive than that of Dr. Fancher. Dr. Fancher opined that claimant's overuse syndrome was a recurrence of the same symptoms that she had experienced in 1989 and did not represent any pathologic worsening of her underlying condition. (Exs. 17 and 31). However, Dr. Fancher based his opinion on the location of claimant's symptoms, without distinguishing between claimant's overuse syndrome, a muscular condition, and her carpal tunnel syndrome, whereas Dr. Snodgrass treated them separately. Moreover, Dr. Fancher offered no explanation of his current opinion that claimant's symptoms were substantially unchanged and indistinguishable from the symptoms she presented with in 1989, despite the new median nerve involvement in 1993. See Somers v. SAIF, supra; Moe v. Ceiling Systems, supra.

We conclude that CNA has carried its burden of establishing that the claimant's work activities at AIAC's insured were the major contributing cause of the claimant's current right arm overuse condition. See ORS 656.802(2); Georgia-Pacific v. Warren, 103 Or App 275, 278 (1990) (A worsening of symptoms alone is not sufficient unless the medical evidence supports the conclusion that the manifested symptoms are the disease); see also SAIF v. Drews, supra.

Carpal Tunnel Syndrome

We adopt the Referee's opinion on this issue, with the following supplementation.

In contrast to claimant's accepted overuse syndrome, claimant first sought treatment for her carpal tunnel syndrome on February 9, 1993, just subsequent to her employment with AIAC's insured. The Referee relied on the opinions of Drs. Gill, Peterson and Snodgrass to establish that claimant's work with AIAC's insured was the major contributing cause of her carpal tunnel syndrome. Because actual causation with respect to a specific identifiable employer was proven, it is not necessary to rely on ORS 656.308 or a judicially created rule of assignment to determine responsibility for claimant's carpal tunnel condition. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-245 (1984); Bracke v. Baza'r, 239, 249-250; see also Fred A. Nutter, 44 Van Natta 854 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over AIAC's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issues is $1,500, to be paid by AIAC. 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 March 9, 1994 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by AIAC.

In the Matter of the Compensation of
LOLA M. SPRINGER, Claimant
WCB Case No. 93-07471
ORDER ON RECONSIDERATION
Galton, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of our August 22, 1994 Order on Review that set aside SAIF's denial of claimant's right shoulder, arm and hand condition. On September 12, 1994, we abated our August 22, 1994 Order on Review to further consider SAIF's request and provide claimant an opportunity to respond to SAIF's motion. Having received claimant's response, we proceed with our reconsideration.

We briefly summarize the procedural history of the case. Claimant's employer was insured by Liberty Northwest Insurance Corporation (Liberty) from July 1, 1985 through June 30, 1991, and was insured thereafter by SAIF. Claimant filed claims for her right shoulder, arm and hand condition against both insurers. Claimant settled her claim with Liberty before the hearing. (Tr. 1). At the hearing, SAIF denied compensability and responsibility. (Tr. 8).

The Referee upheld SAIF's denial on the ground that claimant's conditions were not related to her work activities. On review, we applied Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994) (a decision issued subsequent to the Referee's order). The claimant in Bennett had filed occupational disease claims for hearing loss against two employers and later entered into a Disputed Claim Settlement (DCS) with the first employer. On Board review, we concluded that because the second employer was the only potentially responsible employer left in the case after the claimant had entered into the DCS with the first employer, the claimant had elected to prove actual causation against the second employer and could not rely on the last injurious exposure rule to establish compensability.

The Bennett court reversed, reasoning that if a claimant can show that employment conditions, which may include conditions to which the claimant was exposed at the first employer, were the major contributing cause of the occupational disease, the claimant may rely on the last injurious exposure rule to prove the compensability of the claim against a later employer by showing that employment conditions there could have caused the condition. Id. at 78.

In applying Bennett, we found that the medical evidence established that claimant's work activities, including her work activities while Liberty was on the risk, were the major contributing cause of her right shoulder, arm and hand condition. We also concluded that her claim against SAIF was compensable because claimant proved that her employment activities when SAIF was on the risk could have caused her condition. See Bennett v. Liberty Northwest Ins. Corp., supra, 128 Or App at 78.

Thereafter, SAIF requested reconsideration of our decision. SAIF argues, among other things, that claimant elected to prove actual causation against SAIF and therefore, the Bennett case does not apply. In other words, SAIF contends that claimant must prove that her employment during SAIF's exposure was the major contributing cause of her occupational disease. In response, claimant states that, although her work activities were the same activities that she had done for several years, there was an increase in activity and a corresponding increase in disability after SAIF came on the risk.

We agree with SAIF that, unlike the claimant in Bennett, claimant here has elected to prove actual causation against SAIF. We base this conclusion on the following reasoning.

In Bennett v. Liberty Northwest Ins. Corp., supra, the court rejected the carrier's argument that the claimant had elected to prove actual causation against a single employer. The court reasoned:

> "Claimant filed claims against both employers; his claim has consistently been that both employers could have contributed to his hearing loss. The DCS does not, by its terms, evidence an agreement by claimant that work at Caterpillar did not contribute in any way to claimant's loss of hearing; nor does it by its terms indicate an election to prove actual causation against Siltec." 128 Or App at 78 (emphasis added).

Here, although claimant's DCS with Liberty is not a part of this record, we may take official notice of any fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(b). We have previously taken official notice of disputed claim settlements. See Kenneth W. McDonald, 45 Van Natta 1252 (1993).

Unlike in Bennett, claimant's DCS with Liberty specifically provides that claimant agreed that her work exposure with Liberty's insured did not contribute in any way to claimant's condition. The DCS provided that "the parties agree and stipulate that there exists a bona fide dispute between claimant and Liberty." The DCS provided, in part, that "the claimant stipulates and agrees that the legal effect of this settlement shall be the same as if the claimant admitted and agreed to the accuracy of the contentions of LIBERTY NORTHWEST INSURANCE CORPORATION as set forth above." Liberty's contentions in the DCS provided, in part:

> "Liberty Northwest Insurance Corporation contends that claimant's right hand, right arm, left hand, left arm, cervical, mid-back, low back with bilateral radiculopathy, thoracic and bilateral scapular conditions, did not arise out of the course and scope of her employment with [the employer]. Liberty Northwest Insurance Corporation further contends that these conditions are not due in major or material part to her on-the-job injury of June 30, 1991, or her work exposure in general with [the employer].

"Liberty Northwest Insurance Corporation further contends that claimant's injury or work exposure did not contribute in any way to the above conditions." (Emphasis added).

In addition, this case is also distinguishable from Bennett in another important respect. Unlike the claimant in Bennett, claimant's position in this case has consistently been that only her employment activities during SAIF's exposure have contributed to her right shoulder, arm and hand condition.

At the hearing, claimant's counsel stated that claimant's right shoulder, arm and hand condition had developed over the past two years. (Tr. 9-10). Claimant's counsel noted that claimant had a history of problems, but he argued that "it did not rise to the extent of an occupational disability back until the last two years when it persisted continuously and disabled her." (Tr. 11).

Claimant's appellate brief is also consistent with the theory she expressed at hearing. Although a doctor's report had noted overuse syndrome to her left side in 1989, claimant asserted that "it wasn't until February, 1993 that the intense pain described by Claimant became debilitating." (Claimant's brief at 3). Claimant further argued that she first experienced the condition for which she filed her claim in 1992, during a time when SAIF was responsible for coverage. (Claimant's brief at 4).

We conclude that, unlike in Bennett, claimant has elected to prove actual causation against SAIF. The DCS with Liberty contains express provisions in which claimant specifically agrees that her work activities while Liberty was on the risk did not contribute in any way to her condition. Furthermore, claimant's position at hearing and on Board review has consistently been that her employment activities during SAIF's exposure have contributed to her right shoulder, arm and hand condition. In light of those findings, we conclude that, contrary to the reasoning expressed in our prior order, the Bennett analysis is not applicable to this case. We now proceed to reconsider claimant's appeal of the Referee's order.

To establish the compensability of her occupational disease claim, claimant must prove that her employment activities during SAIF's exposure were the major contributing cause of her right shoulder, arm and hand condition, or its worsening.[1] See ORS 656.802(2). In applying this statutory standard, it is recognized that by settling her claim with Liberty, claimant is deemed to have accepted the possible consequence that she will not receive compensation from the only other potentially causal carrier (SAIF). See E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Lorna I. Young, 46 Van Natta 703 (1994).

SAIF contends that claimant has failed to establish that her exposure with SAIF's insured contributed to a worsening of her underlying condition. We agree.

Considering claimant's extensive history of complaints, the causation of her current conditions is a complex question. Therefore, we rely on expert medical opinion to resolve the issue. See 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 employer was insured by Liberty from July 1, 1985 through June 30, 1991, and was insured thereafter by SAIF. Dr. Zimmerman, claimant's long-time chiropractor, stated that claimant's upper back pain and arm and hand involvement began in 1982. He reported that he had "not seen an indication of pathological worsening in her condition since 1991." (Ex. 14). Dr. St. John, a chiropractor, agreed that there had been no pathological worsening of claimant's condition due to her employment activities since 1991. (Ex. 21). Although claimant's family physician Dr. Brauer stated that claimant's shoulder condition was work-related, he did not state whether or not her work exposure after July 1991 was the major contributing cause of her current condition. (Ex. 20). On the other hand, Dr. Peterson, who examined claimant for SAIF, reported that claimant's current complaints were "definitely" not related to her employment. (Ex. 18).

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[1] SAIF's denial referred to claimant's alleged occupational disease to her neck, upper back, right shoulder and low back. At the hearing, claimant said that her claim was for her right shoulder, arm and hand but did not include her back. (Tr. 28-29).

After considering these opinions, we are unable to conclude that claimant's work activities for the employer while SAIF was on the risk after July 1, 1991 were the major contributing cause of her right shoulder, arm and hand condition, or its worsening. Therefore, claimant has failed to establish the compensability of her condition. See ORS 656.802(2).

Accordingly, on reconsideration, we affirm the Referee's order dated October 12, 1993, as amended October 22, 1993. The parties' rights of appeal shall run from the date of this order

IT IS SO ORDERED.

October 18, 1994 Cite as 46 Van Natta 2216 (1994)

In the Matter of the Compensation of
MARTIN J. STUEHR, Claimant
WCB Case Nos. 93-08880 & 93-05570
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Sedgwick James & Co. (Sedgwick), on behalf of Beaverton School District, requests reconsideration of our September 20, 1994 order. In that order, we concluded that claimant's low back condition was compensable and that Sedgwick was responsible for that condition. In reaching our conclusions regarding compensability and responsibility, we relied on the opinion of Dr. Mason. On reconsideration, Sedgwick contends that our reliance on Dr. Mason's opinion was in error.

Sedgwick argues that Dr. Mason had an inaccurate history regarding the onset of left versus right-sided low back symptoms. On this basis, Sedgwick contends that Dr. Mason's opinion is unpersuasive. We disagree with Sedgwick's contentions.

It does not necessarily follow that Dr. Mason had an incorrect history simply because he made no distinction between right and left-sided symptoms. Although Dr. Mason does not discuss the relative onset of left versus right-sided symptoms, there is no indication that Dr. Mason was unaware of these symptoms or their progression. In addition, it is equally as possible that Dr. Mason was aware of the onset of the left and right-sided symptoms, but found this information irrelevant to his causation analysis. Accordingly, we are not persuaded that Dr. Mason's history was inaccurate.

Sedgwick also argues that: (1) Dr. Mason does not adequately address the impact of claimant's preexisting condition; and (2) there is no indication that Dr. Mason was aware of claimant's distinct fall and the onset of "new" symptoms while working at SAIF's insured. Notwithstanding Sedgwick's contentions, the record does indicate that Dr. Mason was aware of claimant's degenerative condition and was made aware of claimant's fall at SAIF's insured. (Ex. 27). Moreover, there is no evidence that Dr. Mason did not consider the fall or the degenerative condition in reaching his conclusions.

Having considered Sedgwick's contentions, we continue to adhere to our decision to defer to Dr. Mason's opinion, as the surgeon who performed claimant's low back surgery. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Thus, we decline to alter the reasoning contained in our previous order.

Accordingly, our September 20, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 20, 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
RICHARD W. ADMIRE, Claimant
WCB Case Nos. 93-10986 & 93-08694
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Black's order that: (1) declined to admit two exhibits into the record; (2) set aside Liberty's denial of claimant's current bilateral shoulder condition claim; and (3) upheld the SAIF Corporation's denial of claimant's claim for the same condition. On review, the issues are evidence and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee excluded Exhibits 61 and 62, submitted at hearing by Liberty, on the ground that the exhibits were not timely disclosed to SAIF, and good cause for the failure to disclose had not been shown. On review, Liberty contends that the exhibits were improperly excluded. We review the Referee's evidenciary rulings for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

Liberty does not disagree that the exhibits were untimely produced, violating 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."

Although Liberty concedes that the documents were not timely produced, Liberty argues that the Referee did not make a finding that SAIF had been materially prejudiced by the untimely production. We disagree.

At hearing, the Referee considered the arguments of both parties and found that SAIF had been prejudiced because the documents would have changed "their factual view of the case." Additionally, the Referee found that the reason for the failure to disclose was inadvertence on the part of Liberty. (Tr. 7).

We agree with the Referee's ruling that SAIF has been materially prejudiced by the untimely disclosure and that Liberty's inadvertence does not constitute good cause for untimely disclosure of documents. See Kenneth R. Bullion, 46 Van Natta 1262 (1994) (Counsel's absence from the office did not constitute good cause for delay of production); Donald R. Dodgin, 45 Van Natta 1642 (1993)(Untimely production impaired the insurer's ability to prepare its defense, and inadvertence was not good cause for untimely disclosure). Accordingly, we conclude that the Referee did not abuse his discretion in refusing to admit Exhibits 61 and 62 into evidence.

Responsibility

We adopt and affirm the portion of the Referee's order regarding responsibility.

ORDER

The Referee's order dated March 18, 1994 is affirmed.

In the Matter of the Compensation of
DEBORAH D. JOHNSON, Claimant
WCB Case No. 93-10044
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Livesley's order that upheld the insurer's denial of claimant's claim for her current right arm conditions. On review, the issue is compensability.

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

Claimant argues that this case is governed by Lizbeth Meeker, 44 Van Natta 2069 (1992), in which we held that ORS 656.005(7)(a)(B) does not apply to accepted occupational disease claims. There, the claimant's current condition was the same as her accepted occupational disease. Here, claimant's accepted condition is right carpal tunnel syndrome, something other than the conditions for which she currently seeks compensation, viz., right arm reflex sympathetic dystrophy and myofascial pain syndrome. For that reason, we find Lizbeth Meeker distinguishable.

The question remains regarding which legal standard we should apply; viz., whether this matter is governed by the major or the material contributing cause standard. We need not answer that question because, for the reasons set forth in the Referee's order, we agree that, even under the lower standard, claimant's claim fails.

ORDER

The Referee's order dated February 9, 1994 is affirmed.

In the Matter of the Compensation of
JAMES W. JONES, Claimant
WCB Case No. 93-06575
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Lipton's order that set aside its denial of claimant's occupational disease claim for facio-scapulo-humeral muscular dystrophy. On review, the issue is compensability.

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

In finding claimant's facio-scapulo-humeral muscular dystrophy compensable, the Referee applied ORS 656.005(7)(a)(B). Notwithstanding this conclusion, the parties agree that the claim properly is considered as one for occupational disease. Thus, in order to prevail, claimant must show that employment conditions were the major contributing cause of his condition or its worsening. See ORS 656.802(2). A symptomatic worsening is not sufficient; instead, there must be proof of a pathological worsening of the disease. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979).

Contending that claimant showed only a symptomatic worsening of his condition, SAIF asserts that he has not established the compensability of his occupational disease claim. We disagree.

Absent persuasive reasons to do otherwise, we generally give greater weight to the conclusions of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983). We also give more weight to those opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259, 263 (1986).

After applying the aforementioned principles to the medical opinions contained in this record, we rely on the opinion expressed by Dr. Ellison, claimant's treating neurologist. In doing so, we disagree with SAIF's contention that Dr. Ellison's subsequent opinion (which agreed with statements that claimant's work activities were the major contributing cause of a worsening of his preexisting condition) was inconsistent with Dr. Ellison's prior opinions which had referred to claimant's condition as only a symptomatic worsening.

We acknowledge that Dr. Ellison mentioned increased symptoms when describing claimant's complaints arising from his work activities. (Ex. 16A-1). Nevertheless, based on Dr. Ellison's subsequent responses to an insurer-arranged medical examination report from Dr. Mass, and claimant's counsel's letter, we are persuaded that Dr. Ellison was of the opinion that claimant's work activities were the major contributing cause of a worsening of his preexisting condition (which would likely have not become apparent except for the physically demanding nature of claimant's work). (Exs. 25 & 28). This worsening was primarily manifested through muscular weakness and atrophy.

Dr. Ellison's conclusion is also supported by opinions expressed by Dr. Johnston, a neuromuscular specialist for Oregon Health Sciences University. (Exs. 23A & 29). As with Dr. Ellison, Dr. Johnston also referred to increased symptoms in relation to claimant's work activities. (Ex. 23A). However, again like the conclusion ultimately reached by Dr. Ellison, Dr. Johnston agreed with statements that claimant's work activities were the major contributing cause of his preexisting condition.[1] (Ex. 29).

SAIF challenges each of these opinions on the basis that they were conclusory "check-the-box" responses to questions posed by claimant's counsel. Although their final reports did contain boxes to check, neither these reports nor their previous submissions were limited to such conclusory answers. To the contrary, both Dr. Ellison and Dr. Johnston had earlier reported on their examinations of claimant, including a description of claimant's complaints in relation to his work activities. Moreover, each physician had supplemented their "check-the-box" response in replying to the questions posed in claimant's counsel's letter to them.

In light of such circumstances, we interpret the physician's subsequent reports as a further evolution and / or clarification of their earlier opinions concerning the effect of claimant's work activities on his preexisting condition. These subsequent reports confirmed that claimant's work activities were the major contributing cause of a worsening of his preexisting "FSH" muscular dystrophy condition.

Finally, we decline SAIF's invitation to rely on the contrary opinions expressed by Drs. Mass, Cline, and Radecki. At most, these physicians attributed claimant's symptoms to his work activities and found no change in his underlying condition. (Exs. 21, 24, & 27). After comparing these opinions with those expressed by Drs. Ellison and Johnston, we find the latter opinions (particularly that expressed by Dr. Ellison) more persuasive in that they are consistent with the onset of claimant's complaints following strenuous work activities accompanied by a weakness and atrophy of his shoulder girdle muscles.

Inasmuch as the compensation awarded by the Referee's order has not been disallowed or reduced, claimant is entitled to an assessed attorney fee for his counsel's services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 25, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

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[1] Dr. Johnston attributed claimant's pain, numbness, and tingling symptoms to nerve dysfunctions over than claimant's "FSH" muscular dystrophy condition. Nevertheless, Dr. Johnston also agreed that claimant's preexisting dystrophy condition had been worsened by his work activities and that those activities were the major contributing cause of that worsening.

In the Matter of the Compensation of
DIANA M. McCOY, Claimant
WCB Case No. 93-10608
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Lipton's order that: (1) found that claimant's injury claim had been properly closed; (2) increased claimant's unscheduled permanent disability award for a psychiatric condition from 11 percent (35.2 degrees), as granted by an Order on Reconsideration, to 31 percent (99.2 degrees); (3) upheld the insurer's denial of claimant's medical services claim for a hot tub; (4) upheld the insurer's "de facto" denials of a medical bill and a water bed; (5) found that claimant was not entitled to reimbursement for attendant care; and (6) declined to assess penalties and attorney fees for allegedly unreasonable claim processing.

On June 7, 1994, we approved the parties' Claim Disposition Agreement (CDA), in which claimant released her rights to workers' compensation benefits (including temporary and permanent disability), except medical services, for claimant's compensable injury. (WCB Case No. C4-01116). In light of such circumstances, the premature closure and permanent disability issues have been resolved. Consequently, those portions of the Referee's order concerning the premature closure and permanent disability issues are affirmed.

On review, the remaining issues are the medical service claims, penalties and attorney fees. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of claimant's request for reimbursement for expenses pertaining to her purchase of a hot tub. The Referee also upheld the insurer's "de facto" denials of a medical bill and a request to purchase a water bed. The Referee reasoned that claimant did not have the requisite medical authorization for the purchase of the hot tub or the water bed. See OAR 436-10-040. The Referee further concluded that the medical bill at issue was noncompensable as palliative care. Lastly, the Referee found no evidence of medical authorization or a request for reimbursement with regards to the attendant care issue.

HOT TUB

Claimant argues that the insurer unreasonably refused to reimburse her expenses in having a hot tub installed at her home. Specifically, claimant asserts that her treating physician, Dr. Fix, M.D., authorized her to purchase the hot tub. We disagree.

Claimant purchased a hot tub, for $4,695, sometime in 1990 or 1991. (Tr. 16).

In a September 10, 1992 letter to claimant's attorney, Dr. Fix stated that claimant's attempts at physical therapy had been unsuccessful because she lost all the benefits gained from a therapy session during the drive back to her home. (Ex. 14D-1). Dr. Fix opined that it would be "helpful to have [claimant] install a whirlpool to provide her own heat therapy at home." (Ex. 14D-1). Claimant testified that the distance from her home to her physical therapist was approximately 16 to 20 miles. (Tr. 12).

In an August 12, 1993 letter to the insurer, Dr. Fix diagnosed claimant's compensable injury as either a "neuroma" or a "rent in the fascia lata causing herniation of the vastus medialis aggravated by activity." (Ex. 23). Dr. Fix opined that claimant was experiencing "an unusual type of injury and is not responding and recovering as other patients with similar type of injuries." (Ex. 23). Furthermore, Dr. Fix reiterated his prior statement regarding claimant's long drive to physical therapy (i.e., the September 1992 letter to claimant's attorney) and added: "I have reviewed my chart notes and find a notation on March 19, 1991 indicating that [claimant] is to continue to use a hot tub as often as possible." (Ex. 23).

OAR 436-10-040(8) provides that:

> "Articles such as * * * hot tubs * * * are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury or the process of recovery requires' that the item be furnished. The report must specifically set forth why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

Services provided pursuant to OAR 436-10-040(8) are compensable, whether they are palliative or curative, so long as they are reasonable and necessary, they are the result of the compensable injury, and claimant has established with particularity why she needs the service when the majority of workers with similar injuries do not. Rager v. EBI Companies, 102 Or App 457 (1990) on recon 107 Or App 22, 25 (1991); Elixir Industries v. Lange, 100 Or App 492 (1990).

We find the present case to be analogous to Rager, supra. In Rager, the claimant contended that she required a whirlpool because: (1) whirlpool applications of moist heat were more effective than a tub bath or heating pad; (2) the claimant lived almost 25 miles from the nearest public hot tub facilities; and (3) the claimant was modest and reluctant to use such public facilities. In Rager, the claimant's doctor believed that the therapy was necessary to reduce the claimant's muscular spasms and pain and to allow her to sleep more fully. The court affirmed the Board and agreed with its finding that the claimant had failed to show with particularity why she required a service that the majority of workers with similar injuries did not. Rager, Id at 462-463.

Here, claimant's treating physician, Dr. Fix, opines that claimant's injury has not been responding to treatment as patients with similar injuries usually respond. (Ex. 23). However, Dr. Fix's conclusions do not clearly justify claimant's need for a hot tub. Rather, Dr. Fix merely asserts that such an item would be "helpful." (Ex. 23). Such conclusory, unexplained comments, however, fail to establish, with particularity, why the nature of claimant's left thigh injury, or the process of recovery, requires this type of treatment. Also see Daniel P. Mann, 42 Van Natta 603 (1990); Marianne Reith, 43 Van Natta 1071 (1991) (Benefits for articles such as whirlpools/Nordic Tracks are not appropriate where a public alternative has not been shown to be unavailable. Under such circumstances, the uniqueness requirement of OAR 436-10-040(8) has not been met.)

Accordingly, we find that claimant has not established, with particularity, why she needs a hot tub when the majority of workers with similar leg conditions do not. We conclude that claimant has not met the minimum requirements set forth in OAR 438-10-040(8). Therefore, claimant has failed to establish the compensability of the hot tub.

WATER BED

Claimant contends that Dr. Fix has authorized the purchase of a water bed so that she might sleep on a bed, rather than on the couch, as she has apparently done since the date of injury. However, the medical evidence claimant provides for the medical services request amounts to a singular notation by Dr. Fix in the aforementioned letter to claimant's attorney, dated September 10, 1992. In that letter Dr. Fix states: "A water bed is certainly a logical possibility as far as making [claimant] comfortable enough to be able to lie on her left side." As with the request for a hot tub, this note from Dr. Fix does not satisfy the strict particularity requirements of OAR 436-10-040(8). See Rager v. EBI Companies, supra. Accordingly, we affirm the Referee's decision on this issue.

ATTENDANT CARE

Claimant requests reimbursement for attendant care services provided by her aunt. (Tr. 7). Claimant testified that her aunt moved in with her and provided for claimant's daily needs for a period of two weeks. (Tr. 14). The insurer argues that attendant care was not authorized by claimant's treating doctor, and no claim for reimbursement of those services provided was ever submitted to the insurer.

The alleged authorization for attendant care is contained in Dr. Fix's letter of September 10, 1992; wherein he opined:

> "The third question posed is whether [claimant] needed some assistance for her housework, dressing, bathing and so forth shortly following the onset of her injury. It is my understanding she certainly did need this and actually had someone come in and assist her with housework, dishes, etc. I have no idea as to how long this transpired since her young daughter was capable of assisting her when the daughter was off work." (Ex. 14D-2).

A carrier must provide medical services for conditions resulting from any compensable injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1)(a). Therefore, in order for claimant's attendant care to be a compensable medical service, she has the burden to establish that the care was required for her recovery process. Cf. Robert P. Holloway, Sr., 45 Van Natta 2036 (1993), on recon 46 Van Natta 117 (1994)(Attendant care was compensable where it was requested by the claimant's physicians to assist in his recovery from surgery). Dr. Fix's letter of September 1992 cannot be construed to authorize attendant care as necessary for claimant's recovery following her compensable injury. Rather, Dr. Fix is commenting upon his understanding that claimant's resultant disability prompted her aunt to offer her assistance. Dr. Fix does not state that the process of recovery required this attention.

PALLIATIVE CARE

Lastly, claimant contends that the Referee erred in finding that the medical treatment rendered by Dr. Fix, after the February 11, 1993 Determination Order, was palliative and, therefore, noncompensable. Specifically, Dr. Fix treated claimant with a transcutaneous nerve stimulator (TENS) unit for a period of two weeks. (Tr. 9). However, the treatment was apparently discontinued upon notice from the insurer that it was denying claimant's request for palliative medical services. (Ex. 15C-1).

Claimant argues that Dr. Fix's course of treatment with the TENS unit produced material improvement in claimant's condition. Claimant reasons that objective evidence of material improvement establishes that Dr. Fix was providing claimant with curative, not palliative, medical treatment. (Ex. 15-3); See OAR 436-10-005(31). The insurer disagrees, and maintains that the medical treatment is noncompensable, palliative care. See ORS 656.245(1)(b). Neither party disputes that the medical treatment in question was causally related to claimant's compensable injury.

ORS 656.327(1)(a) provides for review by the Director of medical treatment that is "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services." The Court of Appeals has construed ORS 656.327(1)(a) to vest exclusive jurisdiction over a medical treatment dispute with the Director if a party or the Director "wishes" Director review. Meyers v. Darigold, Inc., 123 Or App 217, 221-22 (1993). According to the Meyers court, if no "wish" for review has been filed, jurisdiction remains with the Board. Id.

In Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993), the court agreed with the Board that a dispute concerning whether medical treatment was palliative or curative could fall within the Director's review authority under ORS 656.327. Id. at 176. However, pursuant to Meyers, the court further found that, if no party "wished" Director review, the Hearings Division and the Board had jurisdiction over the matter. Id.

Here, no party in this case has "wished" for Director review under ORS 656.327(1). Therefore, we have jurisdiction regarding these medical services disputes (including this "palliative/curative" dispute). Meyers v. Darigold, Inc., supra; Theodore v. Safeway Stores, Inc., supra. Accordingly, we next consider whether the disputed treatment is palliative or curative. See ORS 656.245(1)(b).

Curative medical services are those services rendered to diagnose, heal or permanently alleviate or eliminate an undesirable medical condition. OAR 436-10-005(31). Curative medical services are compensable throughout the injured worker's lifetime, so long as those services are materially related to the accepted condition. ORS 656.245(1)(c); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993). In order to be compensated for the requested services, claimant must show that they are necessary for the nature of the injury or the process of recovery. Stoddard v. Credit-Thrift Corp., 103 Or App 283, 286 (1990); ORS 656.245(1).

Therefore, compensable medical services can be curative even after a claimant is determined to be medically stationary and the worker's claim is closed. However, here, we conclude that claimant's treating physician, Dr. Fix, has characterized treatment involving the TENS unit as palliative care. (Ex. 15C-2). Specifically, Dr. Fix concluded that claimant's endurance had not changed materially and that claimant's "post-exercise" pain syndrome continued. Additionally, we find no evidence that the TENS unit has been provided for the purpose of healing, permanently alleviating or eliminating claimant's condition. Thus, we conclude that the course of treatment is properly characterized as palliative care.

Generally, once a worker is medically stationary, palliative medical care is no longer compensable. ORS 656.245(1)(b). However, ORS 656.245(1)(b) provides four exceptions where palliative medical care may be compensable even if a claim is closed:

> "when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. If the worker's attending physician * * * believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the the attending physician may request approval from the director for such treatment."

Here, Dr. Fix's course of treatment with the TENS unit does not fall under any of the palliative care exceptions which would render that care compensable without Director review. Specifically, claimant is neither permanently and totally disabled, nor is the prescribed treatment necessary to monitor the administration of medication, or the status of a prosthetic device. See ORS 656.245(1)(b).

Inasmuch as this issue concerns whether Dr. Fix's treatment of claimant with the TENS unit was compensable palliative care not otherwise provided for under 656.245(1)(b), we conclude that this particular dispute is within the Director's sole jurisdiction. ORS 656.327(1); Hathaway v. Health Future Enterprises, 125 Or App 549 (1993); Daniel K. Bevier, 46 Van Natta 215 (1994); on recon, 46 Van Natta 909 (1994); James F. Shissler, 44 Van Natta 1639 (1992). To have the matter considered, the claimant should request review by the Director pursuant to the Director's rules. ORS 656.327.

Consequently, we affirm that portion of the Referee's order that upheld the insurer's "de facto" denial of claimant's medical services claim regarding Dr. Fix's medical treatment to the extent that it pertained to curative care or compensable palliative care under ORS 656.245(1)(b). That portion of the Referee's order that purported to address the insurer's "de facto" denial of compensable palliative care not otherwise provided in ORS 656.245(1)(b) is vacated.

ORDER

The Referee's order dated December 29, 1993, is vacated in part, and affirmed in part. That portion of the Referee's order that purported to address the insurer's "de facto" denial of compensable palliative care not otherwise provided in ORS 656.245(1)(b) is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOHN J. SAINT, Claimant
WCB Case Nos. 93-10866 & 93-07091
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
William J. Blitz, Defense Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Spangler's order that: (1) upheld the SAIF Corporation's denial, on behalf of Bob's Hamburger Express, of claimant's current left knee condition and surgery; and (2) upheld SAIF's denial, on behalf of Denny's Restaurant, of the same condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Since childhood, claimant has had laterally displaced patellae which periodically dislocate.

In April 1986, Dr. James, claimant's then-treating orthopedic surgeon, performed extensor realignment surgery to stabilize the right knee.

In March 1992, due to claimant's continuing left knee pain from a 1981 injury, Dr. James arthroscopically debrided claimant's left knee traumatic arthritis. At that time, the menisci were noted to be in good condition.

On March 23, 1993, claimant sustained a left knee contusion and subluxation while working for Bob's Hamburger Express. Dr. Matteri, claimant's current treating orthopedic surgeon, obtained an arthrogram. The arthrogram revealed long-standing degenerative changes of the patella, prior incomplete removal of the medial meniscus, and lateral displacement of the patella. The lateral meniscus was intact. Dr. Matteri recommended that claimant undergo extensor realignment surgery to stabilize the left knee.

On August 29, 1993, claimant sustained a left knee contusion and subluxation while working for Denny's Restaurant.

In September 1993, Dr. Matteri performed surgery to realign claimant's left patella. During surgery, Dr. Matteri also debrided traumatic arthritic changes and repaired a torn lateral meniscus.

At hearing, SAIF/Bob's accepted a left knee contusion occurring on March 23, 1993, and SAIF/Denny's accepted a left knee contusion occurring on August 29, 1993.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, SAIF/Denny's respondent brief was rejected as untimely. See OAR 438-05-046(1)(c); OAR 438-11-020(2). Consequently, we have not considered SAIF/Denny's respondent brief in our deliberations.

Compensability

Patella Subluxation

The medical evidence establishes that claimant has preexisting laterally displaced patellae which periodically dislocate. Claimant's current disability and need for medical treatment are due to a combination of his preexisting condition and work injuries. Accordingly, the "resultant" condition is compensable only to the extent the compensable injury is the major contributing cause of the disability or need for medical treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993). After reviewing the medical opinions, we are not persuaded that claimant has satisfied his requisite burden of proof.

The Referee concluded that claimant minimized the extent of his prior subluxations. The Referee relied, therefore, more on the written record than on claimant's testimony. On review, claimant contends that he is a reliable historian. We agree that claimant comprehensively recalled his preexisting condition and was a credible historian with respect to his earlier injuries. However, the issue of causation is a complex question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). Thus, while claimant's testimony is probative, it is not dispositive.

There are five medical opinions on causation. On review, claimant argues that the Referee should have relied on the opinion of Dr. Matteri, based on his status as treating physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). However, where, as here, resolution of a matter involves expert analysis rather than expert external observation, we do not give special deference to a treating physician's opinion. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979).

When an arthrogram revealed lateral displacement of the left patella, Dr. Matteri recommended that claimant undergo extensor realignment surgery to stabilize the knee. Dr. Matteri opined that the March 1993 work injury caused a material worsening of claimant's preexisting condition, and is, therefore, a major contributing cause of his current symptoms and need for surgery. In deposition, Dr. Matteri was asked whether the work injury worsened the preexisting condition by causing a pathological change, or only a symptomatic change, or both. Dr. Matteri testified that due to the extensiveness of the radiographic changes within claimant's knee, it is virtually impossible to determine whether the injury caused pathological changes. Notwithstanding that difficulty, Dr. Matteri assumed that because claimant's symptoms continued after March 1993, there must have been pathological change. (In reaching this conclusion, Dr. Matteri did not compare the findings found by Dr. James during surgery in March 1992 with those Dr. Matteri found in September 1993.) Dr. Matteri reaffirmed, therefore, his earlier opinion that claimant's March 1993 work injury is a major contributing cause of his current symptoms and need for surgery.

Dr. Woolpert examined claimant for SAIF/Bob's in June 1993. He agreed that claimant's knee had probably subluxed and spontaneously reduced in March 1993. However, Dr. Woolpert noted that the most recent subluxation did not significantly alter claimant's knee pathology. Dr. Woolpert explained that 1989 and 1993 x-rays were very similar, and opined that the major contributing cause of claimant's recurrent subluxating patella condition is the lateral displacement of claimant's patellae since childhood.

Dr. Arbeene examined claimant for SAIF/Bob's in August 1993. Dr. Arbeene also reviewed and compared claimant's prior x-rays. He found there had been no further displacement of claimant's left patella since 1989. Therefore, although Dr. Arbeene agreed that claimant had experienced another subluxation in March 1993, he too concluded that the major contributing cause of claimant's current patella subluxation condition is claimant's preexisting condition.

Dr. McKillop performed a records review for SAIF/Bob's in November 1993. Dr. McKillop agreed with Dr. Woolpert's conclusions.

Finally, Dr. Donahoo examined claimant for SAIF/Denny's in December 1993. Dr. Donahoo performed a thorough examination, reviewed the relevant medical records, and took a complete history. Given claimant's extensive history of knee problems, bilateral involvement, knee valgus, and obesity, Dr. Donahoo opined that claimant's knee problems dating back to childhood constitute far more than 51 percent of the need for claimant's ongoing treatment.

We find Drs. Woolpert, Arbeene, and Donahoo's opinions persuasive. See Somers v. SAIF, 77 Or App 259, 262 (1986). On the other hand, we find Dr. Matteri's opinion to be speculative and lacking in explanation and analysis.

Accordingly, we affirm the Referee's conclusion that claimant's work injuries are not the major contributing cause of his current left knee subluxation condition and need for treatment. Therefore, claimant has not proven a compensable patella subluxation claim. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

Lateral Meniscus Tear

It is undisputed that claimant has a preexisting left knee subluxation condition. However, there is no evidence that claimant sustained any prior injury to his left lateral meniscus. Because claimant's lateral meniscus tear is not due to a combination of his preexisting subluxation condition and the compensable contusion, there is no "resultant" condition, and ORS 656.005(7)(a)(B) is not applicable. Gary Stevens, 44 Van Natta 1178 (1992).

Instead, in order to establish a compensable injury, claimant need only prove, by medical evidence supported by objective findings, that his work activities were a material contributing cause of disability or a need for medical treatment. ORS 656.005(7)(a)(A).

Of the five medical opinions in the record, only two physicians discuss the causation of claimant's lateral meniscus tear. Dr. Arbeene opined that the meniscus tear was most likely the result of either the March 1993 injury or the August 1993 injury. Dr. Arbeene noted that the cartilage tear was consistent with the mechanism of both the March 1993 and August 1993 injuries; however, he was unable to determine which injury caused the tear.

Similarly, Dr. Matteri opined that claimant's lateral meniscus tear was caused by one or the other of the industrial injuries. He too noted that the mechanics of both the March 1993 and August 1993 accidents were consistent with a lateral meniscus tear. Considering the April 1993 arthrogram (which did not reveal a lateral meniscus tear), and using "pure" statistical probability, Dr. Matteri posited that the tear occurred during the August 1993 injury with SAIF/Denny's. However, Dr. Matteri qualified his opinion by commenting that he could not honestly assign causation.

Because Dr. Matteri could only say that claimant's lateral meniscus tear was caused by one or the other of the industrial injuries, the Referee concluded that claimant had not proven compensability. We disagree.

Under the "the rule of proof" prong of the last injury rule, a claimant need only prove that an employment-related injury could have caused the disability. Bracke v. Baza'r, 293 Or 239 (1982); Inkley v. Forest Fiber Products Co., 288 Or 337 (1980); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994). Here, both Dr. Arbeene and Dr. Matteri opine that either the March 1993 work injury or the August 1993 work injury caused claimant's meniscus tear. That is sufficient to satisfy claimant's burden of proving that his work activities were a material contributing cause of his meniscus disability. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (Material contributing cause standard applies if condition or need for treatment is caused by the industrial accident).

Responsibility

Had we found that claimant had established a compensable meniscus injury while working for SAIF/Bob's, we would have turned to an application of ORS 656.308(1) to determine responsibility for claimant's current disability. Furthermore, had we determined that claimant had proven a compensable meniscus injury while working for SAIF/Denny's, responsibility under ORS 656.308 would have shifted from SAIF/Denny's only if claimant subsequently suffered a "new compensable injury."

However, ORS 656.308 applies to shift responsibility only after it has been determined that a condition is compensable as to a particular employer/insurer. Martin J. Stuehr, 46 Van Natta 1877, 1879 (1994). ORS 656.308(1) is not applicable where, as here, a determination must be made concerning the assignment of initial liability between successive employers. See Fred A. Nutter, 44 Van Natta 854 (1992). In such cases, as it did before the 1990 amendments, the "substantive rule of liability" prong of the last injury rule, Inkley v. Forest Fiber Products Co., supra, continues to operate to allocate responsibility. See id.

Once the evidence establishes that the last incident is a work-related injury that could cause the subject condition, there is a rebuttable presumption that responsibility lies with the last employer/insurer at the time of the last work-related injury. See Boise Cascade v. Starbuck, 296 Or 238, 244 (1984). In a successive injury context, the last injurious exposure rule provides that, if the second injury does not contribute even slightly to the causation of the disabling condition, the carrier on the risk at the time of the first injury is liable for the second. However, if the second injury contributes independently to the disabling condition, the second insurer is solely liable. Id.

Consequently, responsibility for claimant's meniscus tear is initially assigned to SAIF/Denny's. SAIF/Denny's can transfer responsibility to SAIF/Bob's by showing that the prior injury was the sole cause of the disability or that it was impossible for the injury with SAIF/Denny's to have caused the condition. Starbuck, supra at 244 n. 3.

SAIF/Denny's provides no persuasive medical evidence that claimant's March 1993 injury at SAIF/Bob's was the sole cause of claimant's torn lateral meniscus or that it was impossible for the injury at SAIF/Denny's to have caused the condition. In fact, based on Dr. Matteri's opinion and the April 1993 arthrogram, the medical evidence strongly suggests that claimant's August 1993 injury at SAIF/Denny's was the sole cause of claimant's torn lateral meniscus.[1] Thus, there is no basis for shifting responsibility to SAIF/Bob's. Starbuck, supra. Accordingly, we conclude that SAIF/Denny's is responsible for claimant's left knee lateral meniscus tear.

Claimant is entitled to an assessed attorney fee for prevailing over that portion of the SAIF Corporation's denial, on behalf of Denny's Restaurant, which denied claimant's torn left lateral meniscus. 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 service at hearing and on Board review is $2,500, to be paid by SAIF/Denny's. 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated January 5, 1994 is affirmed in part and reversed in part. That portion of the SAIF Corporation's denial, on behalf of Denny's Restaurant, which denied claimant's torn left lateral meniscus is set aside. The claim is remanded to SAIF/Denny's for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on Board review concerning the torn left lateral meniscus portion of the denial, claimant's attorney is awarded an assessed fee of $2,500, to be paid directly to claimant's attorney by SAIF/Denny's.

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[1] Even if we err in applying the last injury rule, we would continue to find SAIF/Denny's responsible for claimant's meniscus disability. Although unable to "honestly assign causation," Dr. Matteri expressed an opinion (based on the earlier April 1993 arthrogram) that the August 1993 injury with SAIF/Denny's caused that disability. In light of these persuasive observations, we would alternatively find that claimant's injury at SAIF/Denny's (not his injury at SAIF/Bob's) is a material contributing cause of his meniscus disability.

In the Matter of the Compensation of
ARTHUR R. SCHOOLEY, Claimant
WCB Case No. 93-13751
ORDER ON REVIEW
Craig Creel, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Howell's order that upheld the insurer's partial denial of his claim for his current L3-4 and L4-5 disc condition. The insurer moves to dismiss claimant's request for review on the basis that claimant did not file an appellant brief. On review, the issues are dismissal and compensability.

The insurer contends that claimant's request for review should be dismissed based on his failure to file an appellant brief. We disagree. The insurer concedes that claimant timely requested review of the Referee's order. We have previously held that a party's failure to submit an appellate brief does not result in the dismissal of that party's request for Board review. OAR 438-11-020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987). Consequently, we deny the insurer's motion to dismiss and proceed to our review of the compensability issue.

With regard to the compensability issue, we adopt and affirm the Referee's order.

ORDER

The Referee's order dated March 11, 1994 is affirmed.

In the Matter of the Compensation of
CHARLES R. WISNIEWSKI, Claimant
WCB Case Nos. 93-06880, 92-11261 & 93-02715
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
John E. Snarskis, Defense Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Industrial Indemnity Company (Industrial) requests review of that portion of Referee Daughtry's order that set aside its denial of claimant's lumbar stenosis condition. On review, the issues are compensability and scope of acceptance. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," which we summarize as follows.

Industrial accepted claimant's claim for a low back strain injury which occurred on March 27, 1979. At that time, claimant's condition was diagnosed as a "lumbar strain secondary to injury." (Ex. 3-2).

A June 11, 1980 Determination Order closed the claim and awarded 10 percent unscheduled disability "resulting from injury to [claimant's] low back." (Ex. 16A).

Claimant's back pain problems have continued since 1979. On May 15, 1992, he suffered a flare-up of symptoms, after driving a forklift for the employer. He filed a claim for medical services, which Industrial denied. (Ex. 42). The SAIF Corporation denied claimant's injury or occupational disease claim and disclaimed responsibility for claimant's current stenosis condition. (Exs. 35, 39, 40).

The Referee upheld SAIF's denial and no party challenges that portion of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Claimant does not argue that his low back stenosis condition is causally related[1] to the 1979 strain injury which Industrial accepted. Instead, claimant contends (and the Referee held) that the stenosis condition is compensable because the scope of Industrial's general acceptance included that condition. We disagree.

It is undisputed that claimant's current back problems are due to spinal stenosis[2], which resulted from the progression of claimant's longstanding degenerative disc disease. (Ex. 43). However, we cannot say that claimant had a stenosis condition in 1979. (See Exs. 2, 3-7, 3-11). Although x-rays in 1979 revealed degenerative disc disease from L3-4 to L5-S1 "with narrowing at the [L]3-4 and 4-5 interspaces," (Ex. 2), a CT scan indicated no stenosis. (Ex. 3-7). Moreover, no medical evidence

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[1] In this regard, Dr. Erkilla, treating physician stated, "If spinal stenosis has been accepted as cause for a work accident, then the conditions we were dealing with in March and April 1992 was related to the 1979 injury. If spinal stenosis has not been accepted as the cause of the work injury, then the March and April visits were not secondary to the 1979 injury." (Ex. 36).

[2] Stenosis is defined as "narrowing or stricture of a duct or canal." Dorland's Illustrated Medical Dictionary 1579 (27th edition 1988).

indicated that spinal stenosis caused claimant's need for treatment until after the 1979 claim was closed.[3] (See Exs. 3-9, 3-12, 10, 10A-2). Under these circumstances, we conclude that Industrial did not accept claimant's stenosis when it accepted the 1979 injury claim.

Accordingly, because we conclude that Industrial did not accept claimant's stenosis condition and that condition is not work-related, we reverse the Referee's order and reinstate Industrial's denial of that condition.

ORDER

The Referee's order dated October 21, 1993 is reversed in part and affirmed in part. Industrial Indemnity Company's denial and disclaimer of claimant's low back stenosis condition is reinstated and upheld. The Referee's award of a $3,500 assessed fee, payable by Industrial, is reversed. The remainder of the Referee's order is affirmed.

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[3] We note that, in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), the "employer's failure to challenge a [permanent disability] award on the basis that it included an award for a noncompensable condition preclude[d] employer from contending later that that condition is not part of the compensable claim." (Slip Op. at p. 4). Here, claimant contends that his degenerative condition is encompassed within the scope of Industrial's acceptance, not that Industrial's failure to contest claimant's 1980 Determination Order permanent disability award precludes Industrial from contesting the compensability of claimant's stenosis condition under the 1979 low back injury claim. Consequently, Messmer is not controlling.

In any event, in contrast to Messmer, the 1980 Determination Order which closed the 1979 injury claim awarded 10 percent unscheduled permanent disability "resulting from injury to [claimant's] low back," (Ex. 16A), and claimant's stenosis was not identified as a contributing cause until after the 1980 Determination Order became final. Because the unappealed order thus did not include an award for claimant's stenosis, this case is distinguishable from Messmer and Industrial's denial of the noncompensable stenosis condition is not precluded.

October 21, 1994 Cite as 46 Van Natta 2229 (1994)

In the Matter of the Compensation of
AARON D. HARRIS, Claimant
WCB Case No. 93-06162
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Podnar's order that: (1) upheld the insurer's "de facto" denial of a right foot condition; and (2) found that claimant's right ankle injury claim was not prematurely closed. In his brief, claimant also requests remand for the admission of additional evidence. On review, the issues are remand, compensability, and premature claim closure. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has an accepted claim for a right ankle sprain. Following surgery in January 1990, claimant continued to experience right foot and ankle symptoms. Claimant has been diagnosed with reflex sympathetic dystrophy (RSD). (Exs. 8-5, 9, 10). Other physicians have diagnosed a chronic pain syndrome. (Exs. 20A-11, 23-6).

Claimant asserted a "de facto" denial of his right foot and ankle condition. Applying ORS 656.005(7)(a)(A), the Referee found that claimant had not established that he had RSD or that work activity was the major contributing cause of such condition. With regard to a chronic pain condition, the Referee found that such condition was more properly addressed for purposes of permanent disability rather than compensability. Claimant challenges these findings on review, asserting that he proved compensability.

We first note that a claimant need not prove a specific diagnosis in order to establish compensability, if he shows that his symptoms are attributable to work activities. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). Thus, claimant is not required to prove the conditions of RSD or chronic pain syndrome; rather, claimant must show that his right leg symptoms, whether diagnosed as RSD or chronic pain syndrome, are related to his accepted right ankle condition.

In June 1989, claimant injured his right ankle; claimant's symptoms worsened after a November 1989 work accident. In January 1990, he underwent surgery whereby a section of the sural nerve was removed. Claimant continued to experience right foot and ankle symptoms. The record contains numerous opinions regarding claimant's right foot condition.

Dr. Cottrell, examining orthopedist for the insurer, diagnosed RSD of the right foot, largely attributing it to "prolonged loss of use." (Ex. 8-5). Dr. Cottrell also noted that claimant's "disability appears to be out of proportion to the type of injury he had." (Id). Dr. Hutson, claimant's former treating orthopedic surgeon, agreed that claimant had "severe" RSD and was not "faking." (Ex. 9).

Dr. Powell, orthopedist, also examined claimant on behalf of the insurer. Dr. Powell diagnosed right ankle strain related to the June 1989 accident and "history of sympathetic dystrophy." (Ex. 10B-5). Dr. Powell also noted inconsistencies in the examination and found that claimant's "present condition is not entirely due to the injury of June 29, 1989." (Id).

Dr. Hauge, another examining orthopedist for the insurer, diagnosed RSD secondary to the right ankle strain and surgery. (Ex. 14-9). Although finding "some definite pathology", Dr. Hauge also noted "some symptom embellishment with functional overlay." (Id. at 10).

After requesting reconsideration of a February 1993 Determination Order, claimant underwent examination by medical arbiter Dr. Dietz. Dr. Dietz diagnosed a right ankle sprain and chronic pain syndrome, both of which he related to the June 1989 industrial accident. (Ex. 20A-11). Additionally, Dr. Dietz disagreed with the diagnosis of RSD and found "significant functional overlay." (Id. at 11-12).

Dr. Vanderbosch, claimant's current treating physician, indicated that claimant's RSD was related to the June 1989 injury. (Ex. 20B). Dr. Vanderbosch subsequently agreed with Dr. Dietz that claimant did not have the diagnostic criteria for RSD but found that such circumstances made the diagnosis "somewhat less defensible" rather than eliminating it. (Ex. 29).

Dr. Rosenbaum, neurosurgeon, examined claimant on behalf of the insurer and agreed with the diagnosis of chronic right foot pain. (Ex. 23-6). Dr. Rosenbaum also indicated that the June and November 1989 incidents were the "primary" cause of claimant's condition, although he also noted "pain behavior with functional features." (Id).

Finally, Dr. Turco, psychiatrist, examined claimant at the insurer's request. Dr. Turco diagnosed a factitious disorder, which is characterized by the compulsive and intentional production of physical symptoms. (Ex. 24-5). Dr. Turco attributed claimant's symptoms to the factitious disorder. (Id. at 6).

Dr. Powell and Dr. Turco were the only physicians who did not attribute claimant's right foot and ankle symptoms to his injury. Dr. Turco related claimant's condition to a factitious disorder; although Dr. Powell did not explicitly provide an opinion regarding causation, he also appears to attribute claimant's symptoms to psychological factors. We find more persuasive those opinions finding that claimant's right foot and ankle symptoms were caused by the June 1989 injury; those physicians, including Drs. Hauge, Dietz, and Rosenbaum, for the most part rendered such an opinion even though finding functional overlay and symptom embellishment.

Under such circumstances, we find a preponderance of evidence that, although claimant exhibited functional overlay, his right foot and ankle symptoms were caused by a pathological condition and not simply psychological factors. Therefore, we find that the opinions of Dr. Turco and Dr. Rosenbaum are not based on an accurate understanding of claimant's condition and that the remaining medical opinions are more persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Furthermore, the record supports a finding that claimant's right foot and ankle symptoms were caused by the industrial injury rather than a condition that resulted from the industrial injury. Therefore, claimant need only prove that the injury was a material contributing cause of his right foot and ankle symptoms. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Having found the opinions of Dr. Turco and Dr. Powell to be less persuasive, based on the remaining evidence, we find that claimant carried his burden. Therefore, we conclude that claimant proved the compensability of his right foot and ankle symptoms, whether diagnosed as RSD or chronic pain syndrome.

Inasmuch as claimant has prevailed on review over the insurer's "de facto" denial of his right foot and ankle condition, he is entitled to an assessed fee for services at hearing and review regarding this issue. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's and reply briefs), the complexity of the issue, the value of interest involved, and the risk that claimant's counsel might go uncompensated.

Remand

In his brief, claimant moves for remand to the Referee for admission of evidence generated after the hearing. Such evidence pertains to the compensability of his right foot and ankle symptoms. Inasmuch as we have found that claimant proved such condition compensable, we find that the case is not improperly, incompletely or otherwise insufficiently developed and we deny the motion. See ORS 656.295(5).

Premature Claim Closure

A February 1993 Determination Order closed claimant's claim, finding claimant medically stationary on July 6, 1992, and was affirmed by a May 1993 Order on Reconsideration. Claimant also challenges the Referee's finding that the claim was not prematurely closed.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to show that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). Furthermore, inasmuch as we have found compensable claimant's right foot and ankle symptoms, we consider such condition in determining whether claimant carried his burden.

In July 1992, claimant was evaluated by the Northwest Occupational Medicine Center at the insurer's request; the center issued two reports. In the first report, hydrotherapy was recommended for claimant's right ankle; however, the report further indicated that claimant's condition was "stationary." (Ex. 11-8). The second report, which was addressed to claimant's treating physician, Dr. Vanderbosch, indicated that claimant, "from a functional point of view, can benefit from a more aggressive rehabilitative approach to his problem" and recommended a referral to a physiatrist. (Ex. 12-2).

Dr. Vanderbosch subsequently indicated that he "received the report from Northwest Occupational Medicine Center and I would tend to agree with the findings." (Ex. 13). Dr. Vanderbosch also agreed that the recommendation for physical therapy was "appropriate to possibly improve some of his incapacitation, but with no expectation that it will change the findings of the pain and sensory changes at all." (Id).

In January 1993, Dr. Hauge reported that claimant was "improving with his current palliative care, and it might reasonably be continued for a brief period of time because of his functional improvement." (Ex. 14-9). Dr. Vanderbosch subsequently reported that he agreed entirely with Dr. Hauge's report "except for the notation that [claimant] is improving with current palliative care." (Ex. 16). Dr. Vanderbosch agreed, however, with the "idea of watching a little longer but not [more than two months]." (Id).

Finally, medical arbiter Dr. Dietz, based on an April 1993 examination, found claimant medically stationary but further indicated that he could not state with certainty "whether his condition was medically stationary on July 6, 1992." (Ex. 20A-12).

We conclude that claimant proved he was not medically stationary at the time of the February 1993 closure. First, although one report found claimant medically stationary on July 6, 1992, another report from the same medical center recommended further medical treatment to benefit claimant "from a functional point of view." Dr. Vanderbosch similarly found that such treatment would benefit claimant's "incapacitation", although not his pain or lack of sensation.

Based on the latter reports, we find evidence of an expectation that, functionally, claimant's condition would materially improve with further medical treatment. This finding is further supported by Dr. Hauge's January 1993 report, and Dr. Vanderbosch's concurrence, recommending continuation of treatment "because of claimant's functional improvement." Finally, although Dr. Dietz found claimant medically stationary in April 1993, he further indicated that he could not determine "with certainty" claimant's status in July 1992.

Based on such evidence, we conclude that claimant was not medically stationary at the time of the February 1993 closure. In particular, we find that the sole report declaring claimant medically stationary is overcome by the evidence showing an expectation of functional improvement with medical treatment. Cf. Maarefi v. SAIF, 69 Or App 527 (1984 (fluctuating symptoms and/or a need for continuing medical treatment does not necessarily mean that a claimant's condition is not medically stationary). Therefore, we conclude that the February 1993 Determination Order prematurely closed the claim.

ORDER

The Referee's order dated November 24, 1993, is reversed. The insurer's "de facto" denial of claimant's right foot and ankle condition is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by the insurer.

The February 1993 Determination Order and May 1993 Order on Reconsideration are set aside. Claimant's right foot and ankle claim is remanded 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. The remainder of the order is affirmed.

In the Matter of the Compensation of
VIRGINIA L. LAWRENCE, Claimant
WCB Case No. 93-07680
ORDER ON REVIEW
Daniel Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Howell's order that: (1) found that claimant's neck injury claim was not time barred; and (2) set aside its denial of that claim. The insurer argues that the claim should be analyzed under ORS 656.005(7)(a)(B). On review, the issues are timeliness and compensability.

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

We agree with the Referee that the insurer had timely notice or knowledge of claimant's work injury. Moreover, even if such notice or knowledge was lacking, we would find that the claim is not time barred because the insurer has not established that it was prejudiced by late notice or knowledge.

Under ORS 656.265(4)(a), claimant's injury claim is not time barred if the insurer was not prejudiced by late filing.

> "The burden is on the [insurer] to prove prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 605 P2d 1175 (1980). Passage of time alone is not sufficient to prove prejudice; the [insurer] must show actual prejudice. Argonaut Ins. Co. v. Mock, 95 Or App 1, 6, 768 P2d 401, rev den 308 Or 79 (1989). It must offer facts, not merely

conclusory statements or speculation, to make its showing. Nat. Farm. Ins. v. Scofield, 57 Or App 23, 26, 643 P2d 1290 (1982)."

Aetna Casualty Co. v. Kupetz, 106 Or App 670 (1991).

In this case, the insurer argues that it was prejudiced by claimant's failure to give timely notice of her neck injury, because it was thereby unable to promptly investigate the circumstances surrounding the accident (including determining whether the injury occurred within the course and scope of claimant's employment) and unable to obtain a contemporaneous medical report from a doctor of its choosing. We are not so persuaded.

The insurer offered no medical opinion suggesting that the absence of a contemporaneous medical examination made it difficult or impossible to determine whether there was a causal relationship between the March 12, 1990 fall at work and claimant's herniated disc at C4-5. See Jann L. Quick, 46 Van Natta 1133, 1134 (1994); see also Donald H. Becker, 44 Van Natta 390 (1992) (If anyone was prejudiced by late claim filing, it was claimant not the insurer). Moreover, considering the medical evidence that claimant's disc herniation is more consistent with the 1990 trauma than with any other cause, (Ex. 25-8-12), we do not find it likely that earlier investigation would have yielded more or better information than was ultimately uncovered. See Leslie Thomas, 44 Van Natta 200, 201 (1992). Thus, because the insurer offered no evidence supporting its assertion that it was prejudiced by its inability to investigate or obtain evidence, we conclude that the insurer has not proven actual prejudice due to the timing of this claim. Accordingly, we agree with the Referee that the claim is not time barred.

Finally, we do not find that claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B), because there is no indication that claimant's work injury "combines with" a preexisting condition to cause her current need for treatment as required by the statute. Accordingly, we conclude that the Referee properly applied ORS 656.005(7)(a) and the "material contributing cause" standard of proof.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated March 7, 1994 is affirmed. For services on review, claimant's counsel is awarded a $2,200 attorney fee, payable by the insurer.

October 21, 1994 Cite as 46 Van Natta 2233 (1994)

In the Matter of the Compensation of
ROBERTO RODRIGUEZ, Claimant
WCB Case No. 93-06124
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Claimant requests reconsideration of our August 30, 1994 order that reversed a Referee's order which had affirmed an Order on Reconsideration award of 31 percent (99.2 degrees) unscheduled permanent disability for a low back condition. On September 28, 1994, we abated our August 30, 1994 order to further consider claimant's request and provide the SAIF Corporation with an opportunity to respond to claimant's motion. Having received SAIF's response, we proceed with our reconsideration.

Claimant objects to our evaluation of the medical opinions. In particular, claimant challenges our conclusion that the arbiters were doubtful of the reliability of all of the range of motion measurements. After discussing claimant's range of motion measurements, the medical arbiters reported that "[t]his does not satisfy the reproducibility-reliability criteria as defined by the 3rd Edition AMA." (Ex. 28). On reconsideration, we adhere to our conclusion that the arbiters were doubtful of the reliability of all of their range of motion measurements, not just for lumbar flexion.

Claimant also contends that we failed to address his alternative argument that he is entitled to a 5 percent award for a chronic condition limiting repetitive use of the lumbar spine. In order to be entitled to an unscheduled 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 at least a partial loss of ability to repetitively use a body part. Donald E. Lowry, 45 Van Natta 1452 (1993).

Claimant relies on the medical arbiters' report that concluded that he "will be permanently precluded from repetitively performing lifting and bending tasks involving his low back." (Ex. 28). The arbiters reached this conclusion notwithstanding their observation that claimant had significant histrionic-type pain behavior and their comments that claimant's range of motion measurements were not valid. Based on the arbiters' conclusion concerning claimant's permanent repetitive use limitations, we conclude that claimant is entitled to 5 percent for a chronic condition for his lumbar spine. OAR 436-35-320(5).

We turn now to a determination of the values for age, education and adaptability. 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 at the time of the Determination Order or Notice of Closure. Former OAR 436-35-003(2). Therefore, we apply the standards in WCD Admin. Order 6-1992, which were in effect at the time of the September 25, 1992 Determination Order.

Age

For workers under 40 years old the standards assign a value of 0. Because claimant is under 40 years old, the appropriate value for age is 0. Former OAR 436-35-290(2).

Formal Education

Because claimant had not earned or acquired a high school diploma or GED certificate at the time of determination, he entitled to a value of 1 for formal education. Former OAR 436-35-300(3)(b).

Skills

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 Christmas-tree farm worker. Former OAR 436-35-300(4). This occupation is assigned an SVP of 2, entitling claimant to a value of 4. DOT 451.687-010; former OAR 436-35-300(4)(e). Claimant does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less, and has not achieved an SVP number of 5 or higher during the ten years prior to determination. Therefore, he is entitled to an additional value of 1. Former OAR 436-35-300(5). Claimant's total education value is 6. Former OAR 436-35-300(6).

Adaptability

Claimant's job at the time of injury is assigned a strength value of "heavy" by the Selected Characteristics Defined in the Dictionary of Occupational Titles (SCODDOT). Here, the medical arbiters found that claimant was capable of returning to work in the light-medium work capacity. (Ex. 28). We conclude that claimant is unable to perform his heavy strength job. Accordingly, we find that claimant's RFC is "medium light" and he is entitled to an adaptability value of 4. 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 his total education value of 6, the sum is 6. When that value is multiplied by claimant's adaptability value of 4, the product is 24. When that value is added to claimant's impairment value of 5, the result is 29 percent unscheduled permanent partial disability. Former OAR 436-35-280.

Accordingly, on reconsideration, the Referee's order dated August 20, 1993 is modified. The Order on Reconsideration award of 31 percent (99.2 degrees) is reduced to 29 percent (92.8 degrees). As modified herein, we adhere to and republish our August 30, 1994 Order on Review. The parties' rights of appeal shall begin to run from this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTA L. BOHEN, Claimant
WCB Case Nos. C4-02165 & C4-02166
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Richard F. McGinty, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Member Neidig and Hall.

On August 23, 1994, the Board received the parties' claim disposition agreements (CDA) in the above-captioned matters. Pursuant to each of those agreements, 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.

By letter dated August 25, 1994, the Board requested an addendum on the basis that the agreements contained the following language:

> "IT IS FURTHER STIPULATED AND AGREED that this settlement shall resolve all issues or claims that were raised or could have been raised as of the date of the approval of this settlement." (P. 5, Ln. 12-14). (Emphasis supplied).

We have previously disapproved a CDA which contained similar language. Victor F. Lambert, 42 Van Natta 2707 (1990). In Lambert, the proposed agreement stated that the parties agreed that the disposition resolved "all issues currently raised or raisable" concerning "outstanding claims for workers' compensation benefits, whether filed or not." (Emphasis supplied). Also see Donna J. Look, 46 Van Natta 1552 (1994). Furthermore, the Board has disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991).

On September 6, 1994, the Board received the parties' addendum. Accordingly, we proceeded with our review.

The parties propose that the following language be substituted in place of the language which the addendum identified as objectionable. The parties' suggested provision provides:

> "It is further stipulated and agreed that this settlement shall resolve all issues that have been raised or that could have been raised before the Workers' Compensation Board concerning this Claim Disposition Agreement as of the date of the approval of this agreement."

After reviewing the parties' proposed language, we find that the provision is distinguishable from the provision found objectionable in Lambert, supra. Here, rather than referring to all claims raised or raisable between them, the parties have expressly limited their settlement to only issues pertaining to this CDA which are raised or raisable before the Board. Accordingly, by phrasing the CDA provision in this narrow and more precise fashion, we find that the provision no longer raises concerns regarding collateral claims or matters that either may not pertain to the accepted claim or that are not within the Board's authority to approve pursuant to ORS 656.236. See Barbara L. Whiting, 46 Van Natta 1684 (1994).

Because we now find that the language specifically pertains to claimant's accepted claim and this CDA, we conclude that such a provision is not unreasonable as a matter of law. Thus, we do not find any statutory basis for disapproving the amended agreement. See ORS 656.236(1). Accordingly, on reconsideration, the CDA, as amended, is approved. An attorney fee of $125, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

Board Member Hall specially concurring:

Since I have concerns with potential future interpretations of the language in this and similar claims disposition agreements, I register the following special concurrence.

To begin with, I refer the parties to the dissent in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994) and the discussion in that dissent concerning the purpose and scope of a claim disposition agreement. I chose to concur in the present case, rather than dissent, because I interpret the addendum contained in the present claims disposition agreement as effectively limiting the "raised or raisable" provision to only those issues lawfully within the Board's authority pursuant to ORS 656.236. I believe, however, that the parties and the forum would be better served if the limitation was explicitly stated in terms of the purpose and scope of claim disposition agreements (thus avoiding confusion with the "raised or raisable" provision commonly contained in a disputed claim settlement). Since a claim disposition agreement is a compromise and release of benefits and/or rights, the release should be expressed in terms of those issues that have been or could be lawfully raised before the Board pursuant to ORS 656.236 concerning the compromise and release of those benefits or rights set forth in the claim disposition agreement. Thus, those in the future charged with the task of interpreting the scope of the "raised or raisable" provision would know it pertained to the lawful compromise and release allowed by ORS 656.236.

In the Matter of the Compensation of
DAVID A. GABILONDO, Claimant
WCB Case No. 93-07796
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requested review of Referee Podnar's order that: (1) set aside its denial of claimant's medical services claim for lumbar surgery; and (2) assessed a penalty for an allegedly unreasonable denial. In its reply brief, however, the employer withdrew its request for review on the issue of medical services. [1] On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because Dr. Franks, the treating doctor, diagnosed a disc bulge encroaching on claimant's spinal canal, and the Western Medical Consultants did not discuss the disc, the employer had no legitimate doubt about its liability for claimant's medical services. 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 the 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 the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, there have been numerous opinions concerning claimant's current condition and need for surgery. Following the compensable injury, Dr. Miller, who first treated claimant, diagnosed lumbar strain. On February 1, 1993, the Consultants opined that claimant's lumbar strain had resulted in no additional permanent impairment, and could be treated with palliative care.

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[1] The employer's request for review specified that all issues decided by the Referee were being appealed. Subsequent to the filing of its appellant's brief and claimant's respondent's brief, the employer withdrew its appeal of the Referee's decision which pertained to the compensability issue.

Because the employer's "withdrawal" did not pertain to the entire Referee's order, we have not dismissed its request for Board review. See Mary J. McFadden, 44 Van Natta 2414 (1992). However, in light of the employer's announcement, we shall only expressly address the penalty issue.

Subsequently, Dr. Miller changed his opinion and reported that claimant's condition was lumbar stenosis, rather than a lumbar strain, and required surgical treatment. Dr. Schmidt, who was also recommending surgery for claimant, reported that he had considered a possibility of the injury making claimant's underlying lumbar stenosis condition symptomatic. However, Dr. Schmidt also noted that claimant's case was "long and complicated and his presentations have often been difficult to sort out."

Consequently, based on the above medical reports, which included a diagnosis from the Consultants which was consistent with the original report of claimant's first treating doctor, we conclude that the employer had a legitimate doubt as to its liability, at the time it issued its denial of surgery. Furthermore, although claimant later changed treating doctors and his new physician, Dr. Franks, diagnosed a disc related to the injury, the Consultants performed an updated chart review and continued to conclude that the injury did not cause claimant's current condition or need for surgery. Therefore, in light of the conflicting medical evidence, we conclude that the employer continued to have a legitimate doubt about its liability for claimant's surgery.

Under the circumstances, we find that the employer's denial was not unreasonable. We, therefore, reverse the Referee's award of a penalty and related attorney fee.

Finally, the employer did not withdraw the "compensability" issue until after claimant had filed his respondent's brief in response to the "compensability" contentions contained in the employer's appellant's brief. Therefore, claimant's attorney has provided services on Board review regarding the compensability issue. Inasmuch as the employer did not withdraw its request for Board review in its entirety, our order is affirming that portion of the Referee's order which upheld the employer's denial. See Mary J. McFadden, supra. In other words, we have found, on the merits, that claimant's compensation awarded by the Referee is not reduced or disallowed. Under such circumstances, claimant's counsel is entitled to an attorney fee for those services devoted to the compensability issue under ORS 656.382(2). Agripac, Inc., v. Kitchel, 73 Or App 132, 136 (1985).

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 compensability issue is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 24, 1994 is reversed in part and affirmed in part. That portion of the Referee's order that assessed a penalty is reversed. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by the employer.

October 24, 1994 Cite as 46 Van Natta 2237 (1994)

In the Matter of the Compensation of
LARRY W. GANGE, Claimant
WCB Case Nos. 90-21432 & 90-15533
SECOND ORDER ON RECONSIDERATION
Estell & Bewley, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys

Pursuant to our October 14, 1994 Order on Reconsideration, we republished our September 15, 1994 Order on Remand, which found that EBI Companies had failed to prove a "new compensable injury" under ORS 656.308(1) and SAIF v. Drews, 318 Or 1 (1993). Consequently, in response to EBI's motion for reconsideration, we continued to hold that responsibility for claimant's low back condition remained with EBI, rather than the SAIF Corporation.

We have now received claimant's motion for reconsideration. Asserting that the proper standard is whether the "second injury" is the major contributing cause of a "worsening" of the condition (rather than the "overall" major contributing cause of the entire condition), claimant seeks

remand to the Referee for further development of the record under the "post-Drews" law. We decline claimant's request for several reasons.

To begin, claimant provides no authority for his contention that in order to shift responsibility under ORS 656.308(1), it must merely be established that the second injury / exposure was the major contributing cause of the "worsening" of the condition. As recited in our prior order, the appropriate standard to determine whether claimant sustained a "new compensable injury" under ORS 656.308(1) and ORS 656.005(7)(a)(B) is whether an accidental injury combined with a preexisting compensable condition and whether that injury is the major contributing cause of the need for treatment and / or disability for the resultant condition. See SAIF v. Drews, supra, 318 Or at 9.

Claimant's "worsening" theory is essentially based on the proposition that since the second injury was the immediate or precipitating cause of claimant's need for treatment or disability, the second injury must be the major contributing cause. The court has recently rejected such an argument, reasoning that under such an interpretation of ORS 656.005(7)(a)(B), an assessment of the relative contribution of different causes for an injury or disease would not occur because the immediate cause would always be the major cause. Dietz v. Ramuda, 130 Or App 397 (1994). Instead, the court has held that, under ORS 656.005(7)(a)(B), the relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances. Id.

Here, after considering the "particular circumstances," we were unpersuaded that claimant's May 1990 lifting incident while working for SAIF's insured was the major contributing cause of his need for treatment and disability for his low back condition. Consistent with that conclusion, we held that claimant had not suffered a "new compensable injury" under ORS 656.308(1) and that responsibility remained with EBI.

After further consideration of our decision, we continue to find the reasoning expressed in our determination to be consistent with prevailing law. We also decline to grant claimant's request for remand for further development of the medical opinions. As discussed in our October 14, 1994 order, we find no compelling reason to remand for the introduction of additional medical evidence based on a subsequent interpretation of ORS 656.308(1), particularly when the present record contains medical evidence regarding the causal relationship between claimant's condition and his employments. See Rosalie S. Drews, 46 Van Natta 408, 410 (1994).

Finally, claimant expresses concern regarding the effect our responsibility determination has on the future processing of his claim. Noting that EBI had already reclosed his claim (in accordance with the Referee's order) shortly before our initial order which reversed the Referee's decision and found SAIF responsible, claimant asserts that "[a]s a result of the Board's [recent] order, it became impossible to prosecute or prove the extent of disability against EBI and its insured."

We do not find that such circumstances establish a basis for remand in this case. All Board decisions have a potential impact on the future rights and obligations of the parties to a claim. Nevertheless, such circumstances do not establish a compelling reason to remand for further development of an already sufficiently developed record.

In conducting our review, the issues before us were responsibility, premature closure of claimant's EBI claim, and (potentially) extent of permanent disability under the EBI claim. On remand, after completing our reconsideration, we affirmed the Referee's order which had found EBI responsible for claimant's low back condition and set aside the closure of claimant's EBI claim as premature.

Although our decision may have a significant effect on claim processing obligations and determinations regarding claimant's EBI claim, that is not an issue within the scope of our review. Therefore, the potential ramifications of our decision do not provide an appropriate ground for remand. However, should such a claim processing issue arise as a result of our decision and the parties are unable to settle the matter, it is then incumbent on the aggrieved party to seek relief through the appropriate channels. At that time, any unresolved processing issue could be fully litigated by the parties based on a completely developed record in that future case.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Complying Status of
MASON-SCANLON CONSTRUCTION, Employer
WCB Case No. 93-14008
ORDER OF DISMISSAL
Roberts, et al., Attorneys
Terry W. Baker, Attorney

Claimant requests Board review of Referee Poland's October 5, 1994 order which dismissed Mason-Scanlon Construction's hearing request from the Director's noncomplying employer order. We dismiss claimant's request for lack of jurisdiction.

FINDINGS OF FACT

On November 19, 1993, Thomas G. Mason and R. Patrick Scanlon dba Mason-Scanlon Construction requested a hearing concerning the Department's order which found them to be a noncomplying employer. No other issues were raised, other than the Director's order.

On September 12, 1994, the Director rescinded the noncomplying employer order. In light of this rescission, the Director moved for dismissal of Mason-Scanlon's hearing request.

On October 5, 1994, in response to the Director's motion, the Referee issued an Order of Dismissal. The Referee's order contained a statement indicating that review of the order should be directed to the Board.

On October 13, 1994, the Board received claimant's request for review of the Referee's order. By this order, we acknowledge that request for review.

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 Department'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).

Here, Mason-Scanlon only requested a hearing regarding the Director's noncomplying employer order. No other issues were raised. In other words, there were no issues raised which constituted a "matter concerning a claim."

Consequently, the Referee's order constitutes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 656/740(1). (3); ORS 656.480(1), (2); Ferland, supra; Spencer House Moving, supra; Jesus Fletes, et al, 45 Van Natta 2252, on recon 45 Van Natta 2376 91993).

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 91990); Gary O. Soderstrom, 35 Van Natta 1710 (1983).[1]

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] The Referee has apparently discovered this oversight. Pursuant to her October 19, 1994 Order of Abatement, the Referee has notified the parties that she retains jurisdiction over her October 5, 1994 Order of Dismissal. Furthermore, in order to consider Mason-Scanlon's motion for reconsideration, the Referee has withdrawn her dismissal order and granted claimant and the Director an opportunity to respond.

October 26, 1994 Cite as 46 Van Natta 2240 (1994)

In the Matter of the Compensation of
WAYNE BENNETT, Claimant
WCB Case No. 91-11454
ORDER ON REMAND
Richard M. Walsh, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994). The court has reversed our prior order that upheld Siltec Corporation's (Siltec) denial of claimant's hearing loss claim. Relying on Garcia v. Boise Cascade Corp., 103 Or App 508 (1990), we affirmed the Referee's order that held that claimant could not rely on the last injurious exposure rule to establish the compensability of his claim. Reasoning that claimant could rely on the last injurious exposure rule to prove the compensability of his claim, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact beginning on page 2 of the Opinion and Order, through the second full paragraph on page 3, with one exception. We omit the sentence on page 3, paragraph 2 that states "Any differences in hearing acuity between the testing last performed at Caterpillar and the first test claimant underwent at Siltec were of a very insignificant nature." We also supplement with the following: "Claimant was also examined by Mr. Velenovsky, an audiologist, who reported results consistent with those of Mr. Frink. (Ex. 17)."

CONCLUSIONS OF LAW AND OPINION

Claimant worked for Caterpillar, Inc. (Caterpillar) and its predecessor beginning in 1964. Claimant worked with heavy equipment and was exposed to noisy conditions. Sometime after Caterpillar purchased the company in the early 1970's, claimant began to use hearing protection and began to notice a hearing loss. By the time claimant left employment with Caterpillar in April 1989, hearing tests had identified a significant bilateral hearing loss.

Claimant did not seek medical attention or file a workers' compensation claim. Claimant did not work again until January 1990, when he began to work in the edge grinder department at Siltec (Liberty Northwest Insurance Corporation's insured). Claimant is also exposed to noisy conditions at Siltec and he wears hearing protection.

In 1991, claimant filed claims for hearing loss against Caterpillar and Siltec. Claimant entered into a Disputed Claim Settlement (DCS) with Caterpillar, in which claimant agreed that his claim with Caterpillar would remain in denied status. At the hearing, Liberty contested compensability and responsibility.

On Board review, we affirmed and adopted the Referee's order. The Referee relied on Garcia v. Boise Cascade Corp., supra, and held that because Siltec was the only potentially responsible employer left in the case after claimant had entered into the DCS with Caterpillar, claimant had elected to prove actual causation against Siltec and could not rely on the last injurious exposure rule to establish compensability.

The court reversed, reasoning that there was no basis for allowing application of the last injurious exposure rule for assignment of responsibility but not as a rule of proof of causation when only one potentially causal employer remains in the case. Id. at 77. The court held that if claimant can show that employment conditions, which may include conditions to which he was exposed at Caterpillar, were the major contributing cause of his hearing loss, claimant may rely on the last injurious exposure rule to prove the compensability of the claim against Siltec by showing that employment conditions there could have caused the condition. Id. at 78.

We must first determine whether claimant's employment conditions, including conditions to which claimant was exposed at Caterpillar, were the major contributing cause of his bilateral hearing loss condition. See ORS 656.802(2); Bennett, 128 Or App at 78. For the following reasons, we are persuaded that claimant has satisfied the requisite standard.

Audiologists Frink and Velenovsky agreed that claimant has bilateral hearing loss and that it results from his long-term employment in a noisy work environment. (Exs. 8, 17, 21, 24, 25-42, 25-43, 25-49, 26-5 & 26-6). Both audiologists agree that the onset of claimant's hearing loss was while he was working for Caterpillar. (Exs. 21 & 24). We conclude that claimant's employment conditions, including conditions at Caterpillar, were the major contributing cause of his bilateral hearing loss.

Claimant may rely on the last injurious exposure rule to prove the compensability of the claim against Siltec by showing that employment conditions there could have caused the condition. Bennett, 128 Or App at 78. Liberty argues that while the record as a whole establishes that claimant may have experienced some actual hearing loss during the time he was employed at Siltec, there is no evidence that that loss was caused by the Siltec employment. Liberty lists other factors that could have caused the worsening, such as testing methods, equipment used and the aging process.

In October 1991, audiologist Frink reported:

> "A comparison between [claimant's] final industrial audiogram at Caterpillar Corporation (02-02-1989) and the audiogram by this office on 10-24-1990, shows a slight (5-10dB) decrease in the hearing acuity of the left ear and negligible decrease in the hearing acuity of the right ear. This would indicate that there was almost no decrease in [claimant's] hearing acuity while he worked at Siltec Corp., and that the major extent of his hearing loss occurred while he was at Caterpillar Corporation * * *." (Ex. 21).

In a December 1991 deposition, Mr. Frink testified that as a "ballpark figure" he estimated that Caterpillar was 95 percent responsible for claimant's hearing loss and Siltec was 5 percent responsible. (Ex. 25-49). Mr. Frink testified that Siltec employment conditions were of the nature which could have contributed to claimant's disability. (Ex. 25-51).

Mr. Velenovsky tested claimant and reported results consistent with those of Mr. Frink. (Ex. 17). At a deposition, Mr. Velenovsky testified that Siltec employment conditions were of the nature which could have contributed to claimant's hearing loss. (Ex. 26-6). According to Mr. Velenovsky, the only significant change between the hearing acuity tests taken while claimant was still employed at Caterpillar and when he became employed at Siltec, was at 4,000 hertz, in the right ear. (Ex. 26-11). He testified that whether there was independent contribution from the Siltec employment was a "gray area," which was at least partially dependent on whether claimant had worn hearing protection correctly. (Exs. 26-11 & 26-12).

As the court noted, the parties dispute how much claimant wore his hearing protection and whether it was properly fitted. Bennett, 128 Or App at 73. Liberty relies on claimant's history as given to the audiologists. Audiologist Velenovsky's July 24, 1991 letter documented that claimant had stated that he wore hearing protection "religiously." (Ex. 17). Mr. Frink concurred with that report. (Exs. 19, 25-2 & 25-14). Liberty argues that the history given to the audiologists is more persuasive than claimant's testimony. We disagree.

At the hearing, the Referee found:

> "Claimant has always worn earplugs while in the employ of Siltec, however for the first ten months of that employment, claimant routinely removed his hearing protection while conversing with co-employees. Claimant has noticed that his hearing seems to be deteriorating since beginning work at Siltec. * * * After claimant was tested by Mr. Frink, he no longer removed his hearing protection while in conversation at his employment." (O & O p.3).

In addition to adopting the Referee's finding that claimant routinely removed his hearing protection while conversing with co-employees at Siltec during the first ten months of that employment, we find that claimant did not always wear properly fitted hearing protection during that time period.

Ms. Williams, an occupational health nurse at Siltec, testified that it was fairly common that employees would pull out their earplugs when engaged in conversations at work until the company started policing that practice in September 1990. (Tr. 66). Claimant testified that he had taken out his earplugs to have conversations with people but he broke himself of that habit. (Tr. 75). He also testified that earplugs provide more protection if he rolls them up tightly and places them back further. (Tr. 75). He said he had been using that technique since he was examined by Mr. Frink. (Tr. 76). Claimant first saw Mr. Frink in October 1990. Since that time, claimant started being more conscientious about the earplugs and he testified that he no longer takes them out to talk to people. (Tr. 76).

Much of the expert testimony provided by audiologists Frink and Velenovsky as to whether claimant's employment conditions at Siltec contributed to his bilateral hearing loss was dependent on whether claimant had consistently worn his hearing protection and whether it was properly fitted. Mr. Frink testified that if claimant "religiously" wore his earplugs at Siltec and they were properly, tightly, lodged in his ears, the chances were "fairly remote" that he would have sustained any additional hearing loss. (Exs. 25-13 & 25-14). However, if the ear plugs were not tightly fitted, they are "almost worthless" because the hearing protection derived from earplugs is "an all or none thing." (Exs. 25-17 & 25-18).

Audiologist Velenovsky testified in a deposition that if claimant wore his earplugs properly and "religiously" while employed at Siltec, there would be no increase in his hearing loss attributable to his Siltec employment. (Ex. 26-9). According to Mr. Velenovsky, under those circumstances, it would not be likely that the change observed at the 4,000 frequency was caused by noise exposure at Siltec. (Ex. 26-17). If, however, the earplugs were not tightly fitted, there would be a "possibility" of a contribution to claimant's hearing loss. (Ex. 26-10).

Liberty argues that although claimant may have experienced some actual hearing loss during the time he was employed at Siltec, factors other than his employment could have caused the worsening, such as testing methods, equipment used and the aging process. We note that there is no evidence of any noise exposure to claimant off the job. Claimant was 52 years old at the time of the hearing. The evidence in this record does not persuade us that the aging process was a significant factor in claimant's hearing loss while he was employed at Siltec.

Similarly, we do not agree with Liberty that the differences in testing methods and equipment used explain claimant's hearing loss while he was employed at Siltec. Mr. Frink testified that even if claimant was previously tested under bad conditions, "there's some validity to the audiograms just from the simple fact that you see a consistent pattern down through the years with [claimant]." (Exs. 25-32, 25-33 & 25-45). Moreover, Mr. Frink testified that the patterns for the type of hearing loss that claimant has, which is a sensori-neural or industrial noise type hearing loss, will usually stay fairly consistent. (Exs. 25-34 & 25-46).

In summary, both audiologists testified that Siltec employment conditions were of the nature which could have contributed to claimant's hearing loss. Moreover, both audiologists reported that claimant's hearing loss increased during his employment with Siltec. Mr. Frink testified that if claimant's ear plugs were not tightly fitted, they were "almost worthless." (Ex. 25-17). In light of our findings that for at least ten months during his employment at Siltec, claimant had not always worn his hearing protection and it was not properly fitted during that time period, we conclude that employment conditions at Siltec could have caused his bilateral hearing loss condition. Bennett, 128 Or App at 78. Consequently, we conclude that claimant's hearing loss condition is compensable.

Claimant has finally prevailed after remand with respect to his bilateral hearing loss 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, on Board review, at the appellate court level, and on remand concerning the compensability issue is $7,750.35, to be paid by Liberty.[1] 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 and Liberty's objections thereto), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We note that claimant is not entitled to an attorney fee for services on remand concerning the attorney fee issue.

Accordingly, on reconsideration of our June 30, 1993 order, the Referee's order dated August 31, 1992 is reversed. Liberty's denial is set aside. The claim is remanded to Liberty for processing in accordance with law. Claimant's attorney is awarded a $7,750.35 attorney fee, payable by Liberty.

IT IS SO ORDERED.

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[1] We note that a different attorney represented claimant before the Court of Appeals. Attorney fee petitions from both attorneys have been submitted for our consideration. We decline claimant's counsel's implicit request for an apportionment of the fees. See Gabriel Zapata, 46 Van Natta 403, 405 n.1 (1994) (manner in which the fee is shared by claimant's current and former counsel is a matter to be decided between the two of them, not this forum). In other words, we award one attorney fee payable by Liberty to claimant's current attorney of record (the attorney who has represented claimant on remand). The particular manner in which that fee will be subsequently distributed among claimant's current and former attorney is a matter between them.

In the Matter of the Compensation of
NORYNN N. CLARK, Claimant
WCB Case No. 93-06537
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

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

FINDINGS OF FACT

We adopt the Referee's findings of facts.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusion, with the following comment.

Based on claimant's testimony, the Referee found that claimant spends approximately two hours a day typing, although occasionally (one to two times a month), she is required to type five to six hours a day. Treating physician Swartzel and consulting physician Soldevilla opine that typing four to six hours a day is the major contributing cause of claimant's carpal tunnel syndrome (CTS). Finding that Drs. Swartzel and Soldevilla based their opinions on histories significantly at variance with his factual findings, the Referee gave no weight to Dr. Swartzel and Dr. Soldevilla's opinions. Thus, the Referee concluded that claimant had not carried her burden of proof.

On review, claimant contends that the Referee misinterpreted her testimony concerning the number of hours she spends typing each day. Specifically, claimant argues that although typing a minimum of two hours a day is "usual," she types five to six hours a day when typing contracts or briefs. Because she types contracts and briefs over several days, claimant explains that she actually spends five to six hours a day typing "several" times a month.

Claimant's testimony at hearing is not inconsistent with her argument on review. Nonetheless, we find that the record supports the facts as found by the Referee. In any event, claimant does not explain how a finding that she spends five to six hours a day typing several times a month (rather than one to two times a month) establishes compensability. Dr. Swartzel and Dr. Soldevilla based their causation opinions on an assumption that claimant types four to six hours every day.

Finally, claimant argues that because whether typing or "stuffing" envelopes, she repetitively uses her hands at work, she has established that work activity is the major cause of her CTS. There is no medical opinion in the record which attributes claimant's CTS to "stuffing" envelopes. Therefore, as did the Referee, we conclude that claimant has failed to carry her burden of proof. ORS 656.266.

ORDER

The Referee's order dated March 3, 1994 is affirmed.

October 26, 1994 Cite as 46 Van Natta 2244 (1994)

In the Matter of the Compensation of
GEOFFREY E. FORCUM, Claimant
WCB Case No. 93-14326
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Daughtry's order: (1) that upheld the SAIF Corporation's denial of claimant's acute back sprain injury claim; and (2) declined to assess a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that, based on his finding that claimant's testimony was inconsistent with that of his former foreman, Mr. Shimp, whom the Referee found credible, claimant had failed to establish the compensability of his acute back sprain. We disagree.

Although the Referee found claimant's testimony unpersuasive, he did not make a specific finding regarding claimant's credibility. We, therefore, make our own credibility findings based on the substance of the witnesses' testimony and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

In September 1993, claimant was employed as a laborer for SAIF's insured, an aggregate and paving company. Claimant testified that, on September 30, 1993, he experienced two episodes of sharp back pain at work, one while raking asphalt, the other while lifting a piece of heavy equipment. The record is clear, and claimant does not dispute, that he did not complain of, or otherwise manifest, pain during either of those episodes. The parties dispute what, if anything, claimant told his foreman, Mr. Shimp, later that day. Claimant testified that, while they were traveling in a truck to another worksite, he told Shimp that he had experienced back pain. Shimp denied that claimant told him about any back pain, and noted that claimant did not appear to be injured.[1]

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[1] Shimp also testified that claimant asked to leave work early September 30, 1993, not because of a back injury, but so that he could perform an off-the-job construction project. At hearing, claimant admitted that he may have asked Shimp if he could leave for that purpose. Because, as the Referee found, there is no evidence that claimant was injured performing the off-the-job project, and because we reject SAIF's argument that Shimp's testimony is incompatible with claimant's version of how he injured his back, we do not consider this evidence in evaluating claimant's credibility.

On direct examination regarding his treatment history at the Bend Orthopaedic and Fracture Clinic (Ex. 1), claimant testified that he had had no prior back injuries. (Tr. 6-8). However, on cross-examination, which concerned his treatment history with the Bachelor Butte Chiropractic Clinic (Ex. 12), he admitted that, in 1986, he had received six chiropractic treatments for back pain that resulted from a wrestling injury. (Tr. 27-28).

On the basis of this evidence, and his finding that Shimp was a credible witness, the Referee concluded that claimant was an unreliable witness. We conclude otherwise. The only evidence that directly conflicts with claimant's version of the events of September 30, 1993 is Shimp's testimony. Although we acknowledge that conflict, we conclude that, on this record, it is not sufficient to support a finding that claimant is not a credible witness. Indeed, based on our review of the evidence, we are unable to find that Shimp is any more credible than claimant.

Furthermore, we are not persuaded that claimant's failure to complain of or manifest pain immediately following the two work incidents on September 30, 1993 is evidence that he is not credible. To conclude otherwise would, on this record, equate stoicism with untruthfulness, something we decline to do.

Finally, we note that claimant's testimony is consistent with the histories given to the treating and examining physicians. (Exs. 2, 4, 8, 11; see also Exs. 3, 5). See Gregg M. Baker, 44 Van Natta 2478 (1992) (in light of fact that the claimant's testimony was consistent with histories given to physicians, conflicting testimony of adverse witness held insufficient to support finding that the claimant was untruthful).

For all of these reasons, we conclude that there is insufficient evidence on which to find that claimant was untruthful. To the contrary, based on his testimony, we find claimant a credible witness. See Coastal Farm Supply v. Hultberg, supra. This conclusion finds support in the testimony of the employer's president, James Curl, and his son, Jeffrey Curl, both of whom testified that they had no reason not to believe claimant's version of the events that transpired on September 30, 1993.

We turn to the causation issue. The reports of both Dr. Johnson, treating physician, and SAIF's examining physician, Dr. Potter, orthopedic specialist, support the compensability of claimant's acute back sprain. (Exs. 8, 11).[2] Furthermore, SAIF does not assert that claimant has failed to establish causation. For these reasons, we conclude that the Referee erred in upholding SAIF's denial of that condition. Accordingly, we reverse the compensability portion of the Referee's order.

Penalties

We adopt and affirm the Referee's penalty analysis.

Claimant's counsel is entitled to an assessed attorney fee for services at hearing and on review concerning 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 attorney fee for claimant's counsel's services at hearing and on review regarding the compensability issue is $3,000, to

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[2] Claimant's theory of compensability is not entirely clear. The medical evidence establishes that claimant had a preexisting spondylolisthesis. (E.g., Exs. 8, 11). Dr. Johnson concluded that claimant's acute back strain was superimposed on the spondylolisthesis. (Ex. 8) Dr. Potter diagnosed resolved lumbosacral strain/sprain secondary to preexisting spondylolisthesis. (Ex. 11-4). This evidence suggests that claimant is relying on ORS 656.005(7)(a)(B). To prevail under that statute, claimant must establish that his acute back sprain is and remains the major contributing cause of his disability and need for treatment. We conclude that claimant has met that burden.

Dr. Johnson concluded that the back strain was the major reason for claimant's current disability and need for treatment. (Ex. 8). In response to the question, "Is the incident of September 30, 1993, a material contributing cause of [claimant's] disability or need for treatment?", Dr. Potter responded, "Yes." (Ex. 11-5). He then went on to explain that claimant had very mild preexisting spondylolisthesis, but that that condition was not the major contributing cause of claimant's disability or need for treatment. (Id). Specifically, Dr. Potter stated that, although the spondylolisthesis may have contributed "slightly", he doubted that it contributed at all to claimant's acute back sprain. (Id. at 6). In light of this analysis, and the fact that the events that transpired on September 30, 1993 are the only other identified cause of claimant's acute back sprain, we conclude that Dr. Potter's report also supports the compensability of that condition under ORS 656.005(7)(a)(B).

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 and reply 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 March 29, 1994 is reversed in part and affirmed in part. The SAIF Corporation's November 24, 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, claimant's counsel is awarded an assessed fee of $3,000, to be paid by SAIF.

In the Matter of the Compensation of
JOSE GOMEZ, Claimant
WCB Case No. 93-07566
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Spangler's order that upheld the SAIF Corporation's denial of claimant's right ankle injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception, correction, and supplementation. We do not adopt the first two paragraphs of the findings of fact. The second sentence in fourth paragraph should read: The employer has been in the tree planting and reforestation business since 1989 and has obtained a total of 14 contracts, two of which were in Oregon.

Claimant, a 28 year-old laborer, is a resident of Eugene, Oregon. A friend of his, who lives in Idaho, became aware of the availability of tree planting work with the employer in Montana through the Idaho Employment Division. (Tr. 41). This friend talked to the employer, who told him to "bring friends" to the job site because they needed people to work. Id. This friend then drove to Eugene and picked claimant up and they both drove to Montana. At the job site in Montana, claimant and his friend filled out job applications and were hired. Id. Claimant had no contact with the employer or anyone associated with the employer's business until claimant arrived at the job site in Montana.

The employer's business was a sole proprietorship from 1989 until he incorporated in October 1991. The employer owns 100 percent of the stock in the corporation and is the president, his wife is the vice president. The employer and his wife are the only year around employees. (Tr. 6, 18, 20-22). All other employees are hired on a job-by-job basis when and if the employer successfully bids on a reforestation contract. The employer will rehire former employees if they have done a good job and are available, but there is no guarantee of future employment. (Tr. 19, 33).

The corporate office is located in Medford, Oregon, and is operated out of the employer's home. Accounting and payroll functions are handled by an accountant in Ashland, Oregon. (Tr. 15-17). The workers on the Montana job were paid from the corporation's Oregon checking account. Id. Supervisory functions were carried out on the job site in Montana.

Over the lifetime of his business, the employer has obtained a total of 14 contracts, two of which were in Oregon. One of these Oregon contracts was performed before incorporation and one was performed after incorporation. Claimant has not worked for the employer in Oregon.

For the Montana job, the employer advertised in Idaho newspapers and listed the job with the Idaho Employment Division. The employer considers Idaho to have a better pool of experienced tree planters than Montana. (Tr. 8-9).

The written agreement between the employer and claimant specified that claimant's employment under the agreement would end approximately June 1, 1993. (Ex. 1A-1). Claimant understood that the Montana job would end on June 1, 1993. (Tr. 50).

Claimant testified that he would work for whomever paid the most. (Tr. 48-49).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the subjectivity issue except that we replace the first three sentences of the section entitled "Circumstances of Claimant's Work Assignment" with the following. A friend of claimant's, who lived in Idaho, found out about the availability of tree planting work in Montana through the Idaho Employment Division. After contacting the employer and being told to "bring friends," claimant's friend drove to Eugene, Oregon and picked up claimant. They drove to the Montana job site, where they were hired to perform a job lasting only through June 1, 1993. (Ex. 1A).

In addition, we add the following supplementation to address claimant's arguments on review.

Claimant argues that the Referee incorrectly applied the "permanent employment relation test" by considering the residence of all of the employees on the Montana job site, rather than considering only claimant's place of residence. We disagree.

The case law clearly states that "the residence of the employees" is one factor, among several, that is weighed in applying the permanent employment relation test, although no single factor is determinative. Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 190 (1992); Berkey v. Dept. of Ins. and Finance, 129 Or App 494, 498 (1994). In fact, in Cervantes-Ochoa, in determining that the Board had correctly applied the permanent employment relationship test in that case, the court noted that the Board found that all of the employer's employees were from the Monmouth, Oregon area. Cervantes-Ochoa, supra, 113 Or App at 191. Thus, the residence of all employees is a factor in the permanent employment relation test. However, the residence of all employees is not itself determinative. Here, the Referee properly considered the residence of all employees, while noting that no one factor controls. Furthermore, we note that mere residence in Oregon is insufficient to make a worker an Oregon employee for the purposes of the Workers' Compensation Law. Hollingsworth v. May Trucking, 59 Or App 531, 535 (1982); Roy L. Center, 44 Van Natta 365 (1992).

Citing Power Master, Inc. v. National Council on Comp. Ins., 109 Or App 296 (1991), claimant argues that, because he is a transient worker, it is inappropriate "to simply look at the sequence of temporary assignments." Instead, claimant argues that "other factors, such as the location of various supervisory and administrative activities should determine the employers [sic] intent." (Appellant's brief, page 5). In making this statement, claimant leaves out part of the equation.

In Power Master, the court held that the Department of Insurance and Finance (DIF) applied the appropriate factors in applying the permanent employment relation test to determine that the workers in question were not Oregon subject workers. Power Master, supra, 109 Or App at 301. In describing those factors, the court noted that:

> "finding that the employees were transient and worked out of many locations, DIF decided that it was inappropriate 'to simply look at the sequence of temporary assignments.' Instead, it focused on other factors, such as the location of various supervisory and administrative activities as well as the intent of the parties, to determine the permanency of the employment relation." Id. (emphasis added).

As a preliminary matter, it is not clear that claimant was a transient employee as to this employer in that, unlike the employees in Power Master, he had not worked out of many locations for this employer. Nevertheless, even assuming that the reasoning in Power Master regarding transient employees applies to this case, the intent of the parties is still a factor in determining the permanency of the employment relationship. Thus, contrary to claimant's argument, the location of supervisory and administrative activities is not determinative, although such factors are considered in determining the permanency of the employment relation.

Here, the administrative activities of calculating payroll and issuing the payroll checks were located in Oregon. However, supervisory activities occurred at the job site in Montana.

In addition, we agree with the Referee that the employer's intent was to hire claimant for temporary work in Montana, with no agreement regarding future work. (Ex. 1A, Tr. 19, 33). Although the employer's wife testified that they would rehire former employees who had done good work, if they were available, she also stated that there was no guarantee for future employment. (Tr. 19, 33). She also testified that no employees are hired unless the company is successful in bidding on a contract. (Tr. 18-20).

Furthermore, we agree with the Referee that claimant did not have a reasonable expectation of working for the employer in Oregon after the Montana job was complete. The written agreement between the employer and claimant specified that claimant's employment under the agreement would end approximately June 1, 1993. (Ex. 1A-1). Claimant testified that he understood that the Montana job would end on that date. (Tr. 50). Claimant also testified that the employer told him that there would "probably" be future work in Idaho and Colorado and "maybe" in Oregon. (Tr. 43-44).

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), aff'd Berkey v. Dept. of Ins. and Finance, supra; 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, supra; Lyle E. Estes, 43 Van Natta 62 (1991).

Claimant, like the claimant in Daryl W. Hugulet, supra, did not have an employment relationship with the employer in Oregon before the out-of-state injury occurred. In that regard, claimant had never worked for the employer in Oregon, found out about the Montana job through contact with a friend from Idaho, and was hired in Montana to perform a temporary job in Montana.

Furthermore, other than the employer and his wife, all other employees are hired on a job-by-job basis when and if the employer successfully bids on a contract. Thus, claimant did not have an Oregon job to return to after the Montana job was finished. Claimant might have anticipated doing a future job in Oregon for the employer if the employer successfully bid on an Oregon contract, claimant was available for work at that time, applied for the job before the crew was filled, and was hired. However, given all of these contingencies, claimant could not have had a reasonable expectation of returning to work for the employer in Oregon after the Montana job was finished. Therefore, claimant's work in Montana was not "incidental" to employment in Oregon. See Roy L. Center, supra; Lyle E. Estes, supra.

In summary, the law is that a worker employed in Oregon who temporarily leaves Oregon to perform work incidental to his Oregon employment is entitled to Oregon workers' compensation benefits if he or she is injured in the course and scope of that incidental work. ORS 656.126(1). Here, claimant was employed in Montana to perform temporary work in Montana, with no reasonable expectation of working for the employer in Oregon. In short, claimant's Montana work was not incidental to any Oregon employment. Accordingly, on this record, claimant has failed to establish that he was an Oregon subject worker for purposes of this claim. See ORS 656.126(1).

ORDER

The Referee's order dated October 15, 1993, as reconsidered on February 9, 1994, is affirmed.

In the Matter of the Compensation of
KEITH D. GREGERSEN, Claimant
WCB Case No. 93-09972
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bullard, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Bethlahmy's order that found that claimant's intestinal injury claim was not prematurely closed. On review, the issue is premature closure. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation and replacement. At hearing, claimant preserved the issue of aggravation. (Tr. 1-2).

We replace the next to last sentence of the findings of fact with the following. Claimant did not have a psychological condition prior to claim closure, nor were there any pre-closure references to any psychological problems.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that claimant preserved the issue of aggravation at hearing. Furthermore, the only issue raised on review is premature closure. Therefore, our review is limited to that issue.

Relying on the opinion of Dr. Bennetts, claimant's treating gastroenterologist, the Referee found that claimant was physically medically stationary at claim closure. We agree.

It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 19, 1993 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

As a result of a work injury, claimant required the surgical removal of about 30 inches of his small intestine. On April 20, 1993, Dr. Bennetts opined that claimant's condition was "medically fixed and stable." (Ex. 34). On May 7, 1993, Dr. Bennetts explained that claimant has a short bowel and, "[i]f he takes in too large a volume of food or a diet too rich in fat, he will experience lower bowel distress, abnormal stools, and some fatigue." (Ex. 37-1). Dr. Bennetts also stated that claimant would have full function and his symptoms would be minimal if he was "absolutely perfect with his diet and matching of Questran [a prescribed anti-diarrheal medication] to his diet." Id. He opined that the period of learning required for claimant to match his diet and Questran "is indeterminate and [claimant] may indefinitely have bad days." Id.

Claimant argues that Dr. Bennetts' opinion only supports a finding that his bowel surgery was medically stationary, not a finding that his diarrhea and fatigue symptoms were medically stationary. In support of this argument, claimant points to Dr. Bennetts' statement that claimant's learning period to match his diet with Questran is "indeterminate." We disagree with this argument.

Dr. Bennetts stated that claimant will not have any change in his disability related to the shortening of his bowel and "in this sense his illness is medically stable and fixed." (Ex. 37-2). However, we do not find that Dr. Bennetts limited his medically stationary opinion to the bowel surgery. Without any qualification, Dr. Bennetts also opined that claimant's claim should be closed. (Ex. 37-2). In addition, he noted that claimant was sustaining good nutrition and stated that:

> "[i]f at any time [claimant] overwhelms his bowel's capacity to handle food by taking more volume of food or more fat density in his diet than his bowel can handle, he will have symptoms. This tendency is fixed, and he will carry it with him the rest of his life." (Ex. 37-2).

In a May 19, 1993 letter to the self-insured employer, Dr. Bennetts explained that claimant "knows already what diet he needs to adhere to in order to stay relatively or nearly free of symptoms. He specifically knows when he exceeds that limits of his diet, he will have to pay for it." (Ex. 39). Given "this perspective," Dr. Bennetts stated that "[i]f [claimant] feels that he needs further direct counseling in his diet, to either help him avoid foods that he knows will cause harm, or to help him understand better the fat content of foods, then I think he would be well served by consulting with either a nutritionist, for food quality, or a psychologist, if it is for food selections." Id.

Finally, in November 1993, Dr. Bennetts agreed that claimant's condition was medically stationary and claim closure was appropriate on April 20, 1993. (Ex. 52A-2).

The only medical opinion that claimant's physical condition was not medically stationary at claim closure comes from Dr. Stanulis, treating psychologist. He opined that only in a surgical sense was claimant medically stationary, relying on Dr. Bennetts' statement regarding the need for continued dietary experimentation for "indeterminate periods of time." (Ex. 55-21). However, as claimant's treating gastroenterologist, Dr. Bennetts has more expertise regarding claimant's intestinal condition. In addition, Dr. Bennetts is the best person to determine what his opinion is regarding claimant's physical condition. Dr. Bennetts found claimant medically stationary at claim closure. Moreover, he confirmed that opinion several months later. (Ex. 52A-2).

Furthermore, a medical condition may be medically stationary and require continuing treatment or fluctuate. Maarefi v. SAIF, 69 Or App 527 (1984). Therefore, Dr. Bennetts' opinion that claimant's symptoms would fluctuate depending on his dietary control and his statement that claimant could be provided with further dietary counseling, if claimant wanted further counseling, do not negate a finding that claimant was medically stationary at claim closure.

Claimant also argues that the fact that he was missing work due to his physical symptoms at the time his claim was closed establishes that he was not medically stationary at that time. However, that is not the statutory standard used in determining medically stationary status. ORS 656.005(17). Claimant also relies on post-closure statements from Dr. Bennetts that his condition has worsened to support his argument that he was not medically stationary at closure. However, post-closure changes in claimant's condition are not relevant to the issue of whether claimant was medically stationary at closure. Sullivan v. Argonaut Ins. Co., supra; Alvarez v. GAB Business Services, supra.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 or App 810 (1983). In this case, we find no such reasons. Therefore, we find that Dr. Bennetts' opinion establishes that claimant's physical condition was medically stationary at claim closure.

Claimant argues that, even if his physical condition was medically stationary at claim closure, his psychological condition was not. Therefore, claimant argues, his claim was prematurely closed. We disagree.

A claimant's injury-produced psychological problems should be considered in determining whether the claim should be closed. Utrera v. Dept. of General Services, 89 Or App 114, 116 (1987). Furthermore, pre-closure references to injury-related psychological problems are sufficient to require the consideration of whether that condition is medically stationary prior to claim closure. Beverly A. Martell, 45 Van Natta 985 (1993); Saura C. Stewart, 44 Van Natta 2595 (1993); Mary J. McKenzie, 44 Van Natta 2302 (1992).

Dr. Stanulis began treating claimant in September 1993, about four months after claimant's claim was closed. Dr. Stanulis opined that claimant suffered from depression, with some features of anxiety, when he began treating claimant. (Exs. 50, 55-9). In addition, Dr. Stanulis opined that Dr. Bennetts' March 10, 1993 chart note indicated that claimant was experiencing psychological problems before his claim was closed. (Ex. 55-21, -22). We disagree.

Parts of Dr. Bennetts' March 1993 chart notes are illegible. However, in the March 10, 1993 note, Dr. Bennetts mentions "functional/stress related bowel syndrome" and "stress coping issued [sic] discussed." (Ex. 28A-2). His March 17, 1993 chart note states, in part:

> ""Pt. under great stress - new job. 'running a warehouse.' Missing work because of Sx - getting far behind - Pressure from Employers not to work past 8 day [sic]. No sleep. 'Exhausted.'" (emphasis in original) (Ex. 28A-2).

These chart notes indicate that claimant was experiencing "stress." However, there is no indication of any psychological condition or problem. In Glenn L. Gatliff, 45 Van Natta 107 (1993), we found the claim properly closed where the claimant did not seek treatment for a psychological condition prior to claim closure, nor was there persuasive evidence that the claimant even had a psychological condition at the time of claim closure. That is the case here. Dr. Bennetts generally referred to claimant's "stress" but he did not indicate that claimant had a psychological condition or problem. Furthermore, we have held that "stress" in and of itself, is not a condition which is generally recognized as a "mental disorder." Nancy L. Lucas, 43 Van Natta 911 (1991); Sharon Schettler, 42 Van Natta 2540 (1990).

In fact, Dr. Stanulis does not opine that the "stress" mentioned by Dr. Bennetts is a psychological condition. Instead, although admitting that he does not know what symptoms Dr. Bennetts was seeing, Dr. Stanulis opines that Dr. Bennetts was seeing some "psychological issues." On the basis of Dr. Bennetts' mention of "stress," Dr. Stanulis opined that "[t]he depression and anxieties are either present then or the precursors to that." (Ex. 55-22). We find Dr. Stanulis' opinion to be too speculative to meet claimant's burden of proof.

While Dr. Bennetts listed "stress" in his March 1993 chart notes, he did not diagnose or treat depression or any other psychological condition, nor did he refer claimant for psychological treatment until August 1993, after he opined that claimant's condition had worsened. (Exs. 45, 46). In addition, Dr. Bennetts' discussion regarding a psychologist "for food selections" does not indicate that claimant had psychological problems before claim closure. (Ex. 39). As discussed above, Dr. Bennetts was addressing the possibility of additional dietary counseling, if claimant wanted it. He made no mention of any psychological problems or condition. Thus, although pre-closure references to injury-related psychological problems are sufficient to require the consideration of whether that condition is medically stationary prior to claim closure, this record does not meet that standard. Beverly A. Martell, supra; Saura C. Stewart, supra; Mary J. McKenzie, supra.

Furthermore, although Dr. Stanulis opined that claimant became disabled psychologically in July 1993, with Dr. Bennetts recommending psychological counseling in August 1993, any post-closure development of a psychological condition is not relevant to the issue of whether claimant was medically stationary at claim closure. Therefore, on this record, we find that claimant was medically stationary at claim closure.

Finally, we note that, in reliance on the examining psychiatrist's opinion and Dr. Bennetts' opinion that any psychological counseling would be merely palliative, the Referee determined that claimant did not develop a psychological condition. Given our above decision, we need not reach the issue of whether claimant developed a psychological condition after claim closure or, if so, whether that condition is compensable. Any post-closure worsening, either physically or psychologically, is not relevant to the issue of premature closure, which is the only issue before us. Therefore, we make no determination regarding the compensability of any post-closure psychological condition.

ORDER

The Referee's order dated January 21, 1994 is affirmed.

In the Matter of the Compensation of
JAY A. NERO, Claimant
WCB Case No. 92-04986
SECOND ORDER ON REMAND
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant requests reconsideration of our October 6, 1994 Order on Remand that found claimant entitled to a penalty under ORS 656.268(4)(g). Specifically, claimant requests an attorney fee under ORS 656.382(1) on the ground that the self-insured employer's claim closure was unreasonable. Alternatively, claimant seeks an attorney fee under ORS 656.388(1) for his counsel's services at hearing and on review, on the ground that claimant finally prevailed on remand from the Court of Appeals.

We withdraw our October 6, 1994 order for reconsideration. After considering claimant's motion, the record, and pertinent legal authority, we decline to award claimant an assessed attorney fee.[1]

First, claimant contends that he is entitled to an assessed attorney fee under ORS 656.382(1) because the employer's claim closure was unreasonable. We considered this issue in our original June 18, 1993, Order on Review and declined to award an attorney fee. We agree that claimant's counsel may be entitled to an attorney fee under ORS 656.382(1) if the carrier's closure constituted an unreasonable resistance to the payment of compensation, but claimant's counsel is not automatically entitled to an attorney fee when a penalty under ORS 656.268(4)(g) is awarded. See Jesus R. Corona, 45 Van Natta 886 (1993).

Here, the employer closed the claim with no award of permanent disability, based on the attending physician's closing examination which found no permanent impairment or disability. After reconsideration, we continue to find that the employer reasonably relied on the attending physician's examination to close the claim without an award of permanent disability. In particular, we note that the employer's reliance on the attending physician's impairment findings is consistent with the statutory mandate of ORS 656.245(3)(b)(B) (only the attending physician at the time of claim closure may make impairment findings for evaluating the worker's disability). Accordingly, we conclude that the employer's claim closure without an award of permanent disability does not constitute unreasonable resistance to the payment of compensation. Claimant's counsel is not entitled to an attorney fee under ORS 656.382(1).

Next, claimant contends that he is entitled to an assessed attorney fee under ORS 656.388(1) for finally prevailing on the ORS 656.268(4)(g) penalty issue after remand from the Court of Appeals. ORS 656.388(1) provides, in pertinent part:

> "No claim or payment for legal services by an attorney representing the worker or for any other services rendered before a referee or the board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the referee or board * * *. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum." (emphasis added).

Here, claimant finally prevailed after remand from the Court of Appeals on the issue of his entitlement to a penalty under ORS 656.268(4)(g).

We addressed the question of entitlement to an attorney fee under ORS 656.388(1) when a claimant finally prevails after remand on a penalty issue in Cleo I. Beswick, 43 Van Natta 1314 (1991).

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[1] There is no evidence that claimant served a true copy of his motion for reconsideration on the other party or its attorney, as required by Board rules. OAR 438-05-046(2). Under such circumstances, we do not consider claimant's document to be a validly filed motion, and we ordinarily would not withdraw our order for reconsideration. However, inasmuch as the outcome of our original order will not change after reconsideration, we address the merits of claimant's motion.

In Beswick, we reasoned that because penalties and attorney fees do not constitute "compensation," claimant did not finally prevail after remand "in respect to any claim or award for compensation" as required under ORS 656.388(1). Cleo I. Beswick, supra, 43 Van Natta at 1315, citing Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc. 80 Or App 233 (1986); see also Juan A. Garcia, 43 Van Natta 2813, 2815 (1991), aff'd mem Garcia v. SAIF, 115 Or App 757 (1992).

We apply the same reasoning in the present case. Inasmuch as claimant prevailed after remand solely on a penalty issue and because penalties do not constitute "compensation," claimant is not entitled to an attorney fee award under ORS 656.388(1).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 6, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 27, 1994 Cite as 46 Van Natta 2253 (1994)

In the Matter of the Compensation of
SAEDEH K. BASHI, Claimant
WCB Case No. 93-13964
ORDER ON REVIEW
Nancy FA Chapman, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Hazelett's order that did not award her 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.

Claimant's only contention on review is that she is entitled to an attorney fee pursuant to ORS 656.386(1) related to the insurer's rescission of its alleged "de facto" denial of her right ulnar neuropathy. We disagree.

A referee's scope of review is limited to the issues raised by the parties. Marvin E. Robb, 46 Van Natta 1764 (1994). As a general rule, an issue listed in a request for hearing is sufficiently "raised" to allow the Board to address the issue on review. See Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458 (1991) (case remanded to Board to address issue raised in prehearing pleadings); see also Murray L. Johnson, 45 Van Natta 470 (1993) (following Alonso). Here, although claimant's request for hearing indicated "attorney fees" (without citing a specific statute) among the issues to be litigated at hearing, we find a persuasive reason to distinguish Alonso and the decisions following it from the case at bar.

Claimant's request for hearing identified the issues to be litigated as compensability, "de facto/prospective denial & 7/23/93 denial[;] 15[-]day rule may apply," as well as attorney fees and penalties.[1] At hearing, the parties stipulated that, shortly before hearing, the insurer had accepted a claim for right ulnar neuropathy. (Opinion and Order at 2). As a result of the insurer's acceptance, the compensability of the ulnar nerve condition became a moot issue.[2]

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[1] Claimant withdrew the 15-day rule issue at hearing.

[2] The only issues litigated at hearing were compensability of claimant's progressive systemic sclerosis or diffuse scleroderma, the insurer's alleged "de facto" or prospective denial of possible future diagnosis services related to her compensable right hand strain, and the timeliness of claimant's request for hearing regarding the insurer's denial of claimant's progressive systemic sclerosis or diffuse scleroderma. (Tr. 2; Opinion and Order at 1).

Claimant's entitlement to a fee pursuant to ORS 656.386(1) regarding her right ulnar nerve condition is dependent on her prevailing on the issue of the compensability of that condition, either through adjudication or by convincing the insurer to accept the claim prior to hearing. Because the compensability of claimant's ulnar nerve condition was no longer an issue at hearing, we conclude that, to preserve the issue of her entitlement to an attorney fee under ORS 656.386(1), at a minimum, claimant had to advise the Referee that she intended to pursue that issue at hearing. Because claimant did not do that, we decline to address the attorney fee issue on review.

Furthermore, we note that the insurer's prehearing "rescission" of its "de facto" denial for the first time brought ORS 656.386(1)'s "obtaining compensation without a hearing" language into play. Inasmuch as that was a new issue that claimant did not specifically raise at hearing, we find it inappropriate to consider that issue now. Compare Barbara J. Fuller, 46 Van Natta 1129 (1994) (Board addressed claimant's entitlement to a fee under ORS 656.386(1), which issue had been litigated before the referee).

ORDER

The Referee's order dated March 16, 1994 is affirmed.

In the Matter of the Compensation of
JOHN F. CASSIDY, Claimant
WCB Case Nos. 93-00760, 93-07111, 93-00761 & 93-07110
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Scott Wetzel Service (Scott Wetzel), on behalf of Albertsons, Inc., requests review of those portions of Referee/Arbitrator Podnar's order that: (1) awarded an assessed attorney fee of $1,000 pursuant to ORS 656.386(1) for finally prevailing over its compensability denial of claimant's low back condition; and (2) awarded a "penalty-related" attorney fee of $1,000 for its allegedly unreasonable compensability denial. Integra Claims Service (Integra), on behalf of Fred Meyer, cross-requests review of those portions of the Referee/Arbitrator's order that: (1) set aside its denial of responsibility for claimant's low back condition; (2) upheld Scott Wetzel's denials of the same condition; (3) awarded an assessed fee of $1,000 pursuant to ORS 656.386(1); and (4) awarded a $1,000 "penalty-related" attorney fee. Claimant cross-requests review of that portion of the Referee/Arbitrator's order that declined to award an attorney fee pursuant to ORS 656.307(5) for services at hearing. In his brief, claimant also seeks an attorney fee pursuant to ORS 656.307(5) for services on Board review. In its cross-reply brief, Integra moves to strike Scott Wetzel's brief as untimely filed. On review, the issues are motion to strike, the propriety of Scott Wetzel's "back-up" denial, compensability, responsibility and penalties and attorney fees. Reviewing de novo, we deny the motion to strike, reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the second to last paragraph.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Integra moves to strike Scott Wetzel's brief filed on March 16, 1994, on the grounds that it is untimely. We deny the motion to strike.

On January 6, 1994, the Board received Scott Wetzel's request for Board review. On January 12, 1994, the Board acknowledged that a request for review had been filed. On January 12, 1994, the Board received Integra's request for review. That request was acknowledged on January 12, 1994. On January 18, 1994, the Board received claimant's request for review. That request was acknowledged January 19,

1994. No acknowledgment expressly indicated which party was the appellant and which parties were respondents/cross-appellants. A briefing schedule was mailed to the parties on February 2, 1994. The schedule did not identify which party was the appellant.

Integra filed its brief on February 23, 1994 (the day the appellant's brief was due). Scott Wetzel and claimant filed their respective briefs on March 16, 1994 (21 days after Integra's brief was filed). In light of such circumstances, it is apparent that the parties were operating under the assumption that Integra was the appellant, rather than Scott Wetzel. It is likewise apparent that there was confusion regarding which party was the appellant and which parties were cross-appellants. In light of this confusion, and in the interests of substantial justice (particularly since each party has had an opportunity to respond to the other's contentions), we deny the motion to strike.

Standard of Review

Claimant injured his low back on August 8, 1992 while employed by Fred Meyer (whose claim was administered by Integra). The claim was accepted for a low back strain. (Ex. 13). Claimant returned to his regular work at Fred Meyer and then was subsequently laid off.

On October 3, 1992, claimant began to work at Albertsons. On November 29, 1992, while working for Albertsons, claimant felt an increase in low back pain while lifting a 25-pound box of mushrooms. On December 11, 1992, Scott Wetzel (Albertsons' claims processor) accepted claimant's claim for a strained back. (Ex. 28). On December 28, 1992, Integra disclaimed responsibility for claimant's current low back condition. (Ex. 37). On January 21, 1993, claimant requested a hearing, raising, among other issues, compensability and responsibility.

On January 27, 1993, six days after claimant's claim with Scott Wetzel was closed by Determination Order, Scott Wetzel issued a current condition denial and disclaimer of responsibility for claimant's condition. (Ex. 42). On February 26, 1993, Scott Wetzel issued a "back-up" denial of claimant's claim. (Ex. 47). Scott Wetzel's "back-up" denial explicitly stated that Scott Wetzel was rescinding its prior acceptance of claimant's claim. Id.

On March 10, 1993, Integra denied claimant's current condition. Integra's denial specifically indicated that it was a denial of compensability. (Ex. 48). Claimant appealed the Scott Wetzel and Integra denials. (Tr. 3-4).

On June 11, 1993, the Department issued a "307" order designating Scott Wetzel as the paying agent. (Ex. 59).

At the hearing, counsel for Integra indicated that the compensability portion of its March 10, 1993 denial was withdrawn. (Tr. 25). There is no indication that Scott Wetzel withdrew its "back-up" or current condition denials at, or before, hearing. To the contrary, at the hearing Scott Wetzel contended that, since its February 26, 1993 "back-up" denial was issued within 90 days of its acceptance of the claim, it was not required to establish by "clear and convincing evidence" that claimant's claim was not compensable. (Tr. 28-29).

ORS 656.307 provides for formal arbitration of responsibility cases. Subsection (2) provides that the Director initiate the arbitration proceeding by referring the matter to the Board for appointment of the arbitrator. The referral is made by issuing a "307" order. Acquiescence to the designation of a paying agent pursuant to an order under ORS 656.307 is not an acceptance of the claim. Taylor v. Masonry Builders, Inc., 127 Or App 230 (1994); Allen v. Bohemia, Inc., 125 Or App 205 (1993). In Taylor, supra, compensability was raised and litigated at hearing even though a "307" order had previously issued.

Here, the matter was referred to the Board through issuance of a "307" order. Inasmuch as a "307" order had issued, compensability should not have been at issue at the hearing. See OAR 436-60-180(7). However, prior to issuance of the "307" order, Scott Wetzel had denied claimant's current condition and issued a "back-up" denial of claimant's claim. Likewise, Integra had previously denied the compensability of claimant's condition. Furthermore, claimant had requested a hearing regarding the denials and raised compensability as an issue. Because these denials had all preceded the issuance of the "307" order, we would normally agree that litigation of this case should be conducted as an arbitration proceeding. However, this case raises an exception to that general rule because here, Scott Wetzel continued to contest compensability at the hearing (by arguing that its "back-up" denial of the claim was permissible because it was issued within the 90-day period to accept or deny the claim). (Tr. 28-29).

Consequently, notwithstanding the parties' beliefs at hearing that only "responsibility" was at issue, Scott Wetzel's insistence that it could lawfully revoke its prior acceptance of the claim brought the issue of compensability directly into issue. Such an interpretation is further confirmed by Integra's response to Scott Wetzel's position at hearing when it argued that Scott Wetzel had not met its burden to prove, by clear and convincing evidence, that claimant's claim was not compensable. (Tr. 28).

We generally review an arbitrator's responsibility decision for errors of law. ORS 656.307(2); John L. Riggs, 42 Van Natta 2816 (1990). However, because compensability was brought into contention between the parties at the hearing, we conclude that the order under review is that of a referee rather than an arbitrator. Consequently, our review is de novo based upon the hearing record. See ORS 656.704; 656.295; Jeffrey W. Nelson, 44 Van Natta 1515 (1992) (Board's review was de novo where compensability was brought into contention between the parties at the hearing); Linda A. Fuchs-Perrite, 43 Van Natta 926 (1991) (Board's review was de novo where an insurer issued a compensability denial before issuance of the "307" order).

Propriety of Scott Wetzel's "Back-up" Denial/Compensability

The Referee did not address Integra's arguments concerning the effect of Scott Wetzel's "back-up" denial because he concluded that the arguments raised by Integra at the hearing were rendered moot by the issuance of a "307" order. We disagree. For the reasons previously discuss, the compensability issues raised by the parties should have been addressed by the Referee, notwithstanding the issuance of a "307" order.

On review, Integra argues that Scott Wetzel is responsible for claimant's low back condition because it is the last carrier with an accepted claim for low back strain. See ORS 656.308(1). Integra further contends that Scott Wetzel's subsequent "back-up" denial of claimant's low back claim is improper for two alternative reasons. First, Integra argues that the "back-up" denial is impermissible because it is not based on new evidence obtained after acceptance of the claim. Second, Integra argues that, even if Scott Wetzel's "back-up" denial is permissible under ORS 656.262(6)[1], Scott Wetzel has not met its burden to establish by clear and convincing evidence that claimant's claim is not compensable.[2]

ORS 656.262(6) requires that a "back-up" denial be based on "later obtain[ed] evidence" that a claim is not compensable. See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993). In addition, if the claimant requests a hearing on the "back-up" denial, the denying carrier must prove by "clear and convincing" evidence that "the claim is not compensable." ORS 656.262(6). Here, in order to meet that burden, Scott Wetzel must prove, by clear and convincing evidence, that the November 29, 1992 injury was not the major contributing cause of claimant's disability or need for treatment. See Drews v. SAIF, 318 Or 1 (1993); Darwin G. Widmar, 46 Van Natta 1018 (1994).

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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."

[2] Scott Wetzel argues that since its denial was issued within the 90 day period in which to accept or deny the claim under ORS 656.262(6), it was not a "back-up" denial under that statute. We disagree. We have previously rejected a similar argument in Brian W. Andrews, 45 Van Natta 1515 (1993), aff'd SAIF v. Andrews, 130 Or App 620 (1994). In Andrews, the insurer argued that the portion of amended ORS 656.262(6) which shifts the initial compensability burden of proof from a claimant to an insurer does not apply when an insurer accepts and then denies a claim within the 90-day period permitted under the statute. We held and the Andrews court affirmed that the initial 90-day period stops running at the point of acceptance. From the date of acceptance forward, the "back-up" denial provisions of the statute apply. See also Tamera L. Stevenson-LeClaire, 45 Van Natta 2306 (1993). Accordingly, we reject Scott Wetzel's argument that it does not bear the burden of proving by clear and convincing evidence that the claim is not compensable.

Having reviewed the evidence, we conclude that Scott Wetzel has failed to prove by clear and convincing evidence that claimant did not sustain a compensable injury on November 29, 1992. Accordingly, we find it unnecessary to determine whether Scott Wetzel's denial is based on "later obtain[ed] evidence."

The medical evidence regarding causation comes from Dr. Peterson, examining orthopedist, and Dr. Berkeley, a neurologist who treated claimant. Dr. Dougan, who treated claimant for the August 1992 "Fred Meyer" injury, but who did not treat claimant after the November 1992 "Albertsons" injury, also offers an opinion concerning causation.

Dr. Peterson believed that the November 29, 1992 incident was an exacerbation of claimant's August 11, 1992 injury and was not a new injury. However, Dr. Peterson believed that claimant's need for treatment for about a month after the November 29, 1992 injury was due to the November 29, 1992 incident. Dr. Peterson opined that claimant never made a complete recovery from the August 11, 1992 injury, never experienced a symptom-free interval, and the November 29, 1992 incident was relatively trivial event involving lifting only 20 pounds. Dr. Peterson also opined that there was no objective evidence that the November 29, 1992 incident worsened claimant's underlying condition. Finally, Dr. Peterson opined that the August 11, 1992 injury was the major, if not the sole, cause for claimant's treatment beginning one month after the November 29, 1992 injury. (Ex. 49).

Dr. Berkeley first indicated that the November 1992 injury was an acute exacerbation of the August 11, 1992 injury. (Ex. 44-3). Later, however, Dr. Berkeley explained that claimant's low back condition was probably caused by three factors: his preexisting degenerative disc disease, the August 11, 1992 lifting incident and the November 1992 lifting incident. (Ex. 54). Although Dr. Berkeley opined that all three factors were contributing to claimant's condition, he opined that the November 29, 1992 incident was, chronologically speaking, the immediate major cause of claimant's treatment after November 28, 1992. (Ex. 54). In his deposition, Dr. Berkeley opined that, even if claimant did not recover 100 percent from his August 1992 injury, the November 1992 incident, superimposed on claimant's preexisting condition, was still the major contributing cause of claimant's disability and need for treatment after November 1992. (Ex. 61-17).

Dr. Dougan, who treated claimant for his August 1992 injury, opined that the August 1992 injury was not the major contributing cause of claimant's need for treatment after the November 1992 injury. Dr. Dougan based this opinion on the fact that, the last time he saw claimant in September 1992, claimant was much improved and the August 1992 injury appeared to be resolving.

To be clear and convincing, evidence must be free from confusion, fully intelligible, and distinct. In addition, to be both clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractors v. Tandy Corp., 303 Or 390, 407 (1987). After considering the medical evidence, especially Dr. Berkeley's opinion that the November 29, 1992 incident was the major contributing cause of claimant's disability and need for treatment after November 1992, we conclude that Scott Wetzel has not established by clear and convincing evidence that claimant did not sustain a compensable injury on November 29, 1992.

In summary, we conclude that even if Scott Wetzel's "back-up" denial was permissible, Scott Wetzel has not established by clear and convincing evidence that the claim is not compensable or that it was not responsible for the claim. Accordingly, we set aside Scott Wetzel's denials.

Because Scott Wetzel's "back-up" denial was improper, its prior acceptance of the claim remains in place. Scott Wetzel is responsible for further medical services and disability for claimant's low back condition after November 29, 1992 until claimant sustains a "new compensable injury" involving the same low back strain condition. See ORS 656.308(1); Smurfitt Newsprint v. DeRosset, 118 Or App 368, 371 (1993); Senetra Smith-Wampler, 46 Van Natta 1661 (1994). ORS 656.308(1) does not provide for a mechanism by which a carrier may shift responsibility backward to a prior carrier. See Bonni J. Mead, 46 Van Natta 447, on recon 46 Van Natta 1185 (1994).

Penalties and Attorney Fees

The Referee found that both employers denied compensability and that both employers' denials were unreasonable. Finding that there were "no amounts then due" upon which to base a penalty, the Referee assessed penalty-related attorney fees of $1,000 pursuant to ORS 656.382(1) against both employers. Both Integra and Scott Wetzel contend that penalty-related attorney fees are not warranted.

A denial is not unreasonable if the insurer or self-insured employer had a legitimate doubt as to its liability when the denial was issued. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, the medical evidence in existence at the time of both carrier's denials indicated that claimant's condition was compensable. Although an MRI scan performed on February 15, 1993 showed degenerative disc changes in claimant's lumbar spine, Scott Wetzel did not receive this document until after it issued its February 26, 1993 "back-up" denial. It is not clear from the record when Integra received the MRI report showing degenerative disease. However, at the time Integra issued its denial, there was no medical evidence interpreting the MRI findings to indicate that claimant's low back condition was due to those degenerative changes rather than the work injuries.

Accordingly, we agree with the Referee that the compensability denials of Integra and Scott Wetzel were unreasonable. There is no evidence in the record that there are "amounts then due" on which to base a penalty. Accordingly, a penalty pursuant to ORS 656.262(10) may not be awarded.

A penalty-related attorney fee pursuant to ORS 656.382(1) can be awarded if the conduct of Integra and/or Scott Wetzel constitutes unreasonable resistance to the payment of compensation. ORS 656.382(1). We find that the unreasonable compensability denials amounted to unreasonable resistance to the payment of compensation. See Mark Yakis, 46 Van Natta 142 (1994) (carrier unreasonably resisted the payment of compensation where it issued an unreasonable compensability denial). Inasmuch as both Integra and Scott Wetzel unreasonably resisted the payment of compensation by issuing unreasonable compensability denials, we conclude that attorney fees are warranted against both.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that $1,000 is a reasonable attorney fee for claimant's attorney's services regarding the unreasonable resistance to the payment of compensation by Scott Wetzel and Integra, respectively. 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.

Attorney Fees Pursuant To ORS 656.386(1)

The Referee awarded claimant's attorney a $1,000 fee against both Scott Wetzel and Integra, apparently for counsel's pre-hearing services in obtaining rescission of both employers' compensability denials. We agree that claimant's attorney is entitled to carrier-paid attorney fees. However, we base this conclusion on the following reasoning.

Fee Payable by Integra

Integra challenges the Referee's award of an attorney fee pursuant to ORS 656.386(1). We conclude that the Referee correctly awarded an attorney fee pursuant to ORS 656.386(1), payable by Integra.

ORS 656.386(1) authorizes an award of attorney fees if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held[.]" See Kerry L. Vanwagenen, 46 Van Natta 1786 (1994) (where the carrier had rescinded the compensability portion of its denial prior to hearing, claimant's attorney's request for hearing was sufficiently instrumental to serve as the basis of an attorney fee award pursuant to ORS 656.386(1)); see also Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant's counsel entitled to a carrier-paid fee under ORS 656.386(1) where carrier had rescinded compensability portion of its denial before a hearing regarding responsibility for the claim).

Here, Integra issued a denial of claimant's current condition on March 10, 1993. (Ex. 48). That denial explicitly denied both compensability and responsibility. Claimant's attorney filed a request for hearing listing compensability as one of the issues. In addition, claimant's attorney indicated at the hearing that claimant was contesting Integra's denial. (Tr. 22). Integra's counsel acknowledged at hearing that Integra's denial had been a denial of both compensability and responsibility and clarified that Integra's compensability denial had been withdrawn. (Tr. 25).

In light of Integra's withdrawal of the compensability portion of its denial before the hearing, we conclude that the Referee's award of an attorney fee pursuant to ORS 656.386(1) was appropriate. See Kerry L. Vanwagenen, supra; Penny L. Hamrick, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning rescission of Integra's compensability denial is $1,000, to be paid by Integra. 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 might go uncompensated.

Fee Payable by Scott Wetzel

In finding Scott Wetzel responsible for the claim, we have set aside Scott Wetzel's "back-up" and current condition denials of the claim. Accordingly, since claimant has finally prevailed over Scott Wetzel's denials, he is entitled to an attorney fee pursuant to ORS 656.386(1) for services at 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 assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,500, to be paid by Scott Wetzel. 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. This award is in lieu of the Referee's $1,000 attorney fee award under ORS 656.386(1).

Attorney Fee ORS 656.307(5)

The Referee found that claimant's counsel did not actively and meaningfully participate in the responsibility proceeding and declined to award an attorney fee pursuant to ORS 656.307(5).

On review, claimant seeks an attorney fee pursuant to ORS 656.307(5) for hearing and Board review. Because we have found that this proceeding was not in the nature of a proceeding under ORS 656.307, we conclude that an attorney fee pursuant to ORS 656.307(5) is not appropriate.

ORDER

The Referee/Arbitrator's order dated November 30 1993, as amended on December 30, 1993, is reversed in part, modified in part and affirmed in part. That portion of the Referee's order that found Integra responsible for claimant's low back condition is reversed. Integra's denial is reinstated and upheld. Scott Wetzel's denials are set aside and the claim is remanded to Scott Wetzel for processing according to law. In lieu of the Referee's $1,000 attorney fee award under ORS 656.386(1) payable by Scott Wetzel, claimant's attorney is awarded $3,500, for services at hearing and on review concerning Scott Wetzel's denials, payable by Scott Wetzel. The remainder of the Referee's order is affirmed.

October 27, 1994 Cite as 46 Van Natta 2259 (1994)

In the Matter of the Compensation of
KIMBERLEE S. RINGSTEAD, Claimant
WCB Case No. 93-13235
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Terrall & Associates., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Menashe's order which affirmed an Order on Reconsideration reducing claimant's unscheduled permanent disability award for her neck and upper back condition from 15 percent (48 degrees), as awarded by a Determination Order, to zero. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

On November 24, 1993, the insurer accepted a cervical, as well as a thoracic, strain resulting from the August 23, 1992 work injury. (Exs. 49, 49A).

CONCLUSIONS OF LAW AND OPINION

On April 15, 1993, a Determination Order issued awarding claimant 15 percent (48 degrees) unscheduled permanent disability, based on the closing examination of claimant's treating physician, Dr. Jura. (Exs. 45, 48).

On December 23, 1993, an Order on Reconsideration issued, reducing claimant's permanent disability award to zero, based on a medical arbiter's December 2, 1993 examination. (Ex. 53).

Considering the reports of treating physician Dr. Jura and medical arbiter Dr. Dinneen, the Referee concluded that claimant failed to establish, by a preponderance of the evidence, that she has any permanent impairment attributable to her August 1992 injury. We disagree.

For the purpose of rating the extent of claimant's permanent impairment, we consider only the examinations of claimant's attending physician and the medical arbiter. ORS 656.245(3)(b)(B); 656.268(7); see also Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B); see also OAR 436-35-007(9). The disability standards define the "preponderance of medical evidence" as meaning "the more probative and more reliable medical opinion based upon the most accurate history, on the most objective findings, on sound medical principles and expressed with clear and concise reasoning." OAR 436-35-005(10).

Dr. Jura, claimant's attending physician, performed a closing examination on March 22, 1993. He found that claimant had permanent impairment due to her August 1992 injury, supported by the objective findings of cervical range of motion measurements. (Ex. 45). We find no basis for not accepting Dr. Jura's closing examination.

Dr. Dinneen performed a medical arbiter examination on December 2, 1993 for the purpose of rating claimant's impairment due to her compensable injury. (Ex. 51); see also ORS 656.268(7). Upon physical examination, he found limitations in thoracic and cervical ranges of motion. (Ex. 51-2). He diagnosed claimant's condition as cervical and thoracic spine strains, "objectively resolved." Although his cervical and thoracic range of motion measurements revealed impairment, Dr. Dinneen nevertheless concluded:

> "There is no valid objective evidence of any permanent impairment that can be attributed to the August 23, 1992, incident in a medically probable fashion based on the examination here today." (Ex. 51-3).

We find Dr. Dinneen's examination and report to be less probative and reliable than Dr. Jura's examination. Dr. Dinneen's unexplained conclusion is inconsistent with his physical examination, in which he did make objective findings of impairment relative to claimant's cervical and thoracic spine. There is no indication that the range of motion measurements Dr. Dinneen made were invalid, nor is there any indication that claimant's range of motion limitations are due to any cause other than her compensable injury. Under these circumstances, we find Dr. Dinneen's report to be internally inconsistent and illogical. Therefore, we do not find it to be probative and reliable.

Dr. Jura's closing examination does not suffer from the same infirmities. We find no basis not to accept Dr. Jura's closing examination and cervical range of motion measurements as reported, relative to claimant's compensable injury. Consequently, we rely on Dr. Jura's closing examination for rating the extent of claimant's permanent impairment.

Since claimant's permanent disability award made in the Determination Order was based on the impairment measured by Dr. Jura, and since we find that the medical evidence preponderates in favor of Dr. Jura's findings, we reinstate the 15 percent unscheduled permanent disability awarded by the Determination Order. The Order on Reconsideration is modified accordingly.

Inasmuch as this order increases claimant's 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 decision in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (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, since 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 a substantive increase in claimant's permanent disability on Board review of 15 percent. Consequently, claimant's attorney is entitled to an attorney fee equal to 25 percent of this increased compensation, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award, or any portion thereof, has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.

ORDER

The Referee's order dated February 24, 1994 is modified. In lieu of the Referee's order and Order on Reconsideration which awarded no unscheduled permanent disability, the Determination Order award of 15 percent (48 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane A. Volk, supra.

In the Matter of the Compensation of
BRUCE HARDEE, Claimant
WCB Case No. 92-11644
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Karl A. Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Davis' order that: (1) found that claimant's midback injury claim was not prematurely closed; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for a midback condition. In its respondent's brief, SAIF asserts that the Referee erroneously awarded an assessed attorney fee for a discovery violation. On review, the issues are premature claim closure, aggravation 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

Claimant filed an injury claim for a midback condition occurring on February 27, 1992. The claim was litigated before Referee Podnar who set aside SAIF's denial. Claimant also underwent low back surgery in 1988 and cervical surgery in 1989. On October 13, 1992, SAIF issued a Notice of Closure finding claimant medically stationary on July 28, 1992. A January 7, 1993 Order on Reconsideration awarded additional temporary disability and otherwise affirmed the Notice of Closure.

In this proceeding, the Referee also found that the claim was not prematurely closed and upheld SAIF's denial of an aggravation claim. Claimant challenges both findings.

Premature Claim Closure

We first address claimant's assertion that the Referee allowed SAIF to relitigate issues raised in a prior hearing before Referee Podnar. Specifically, claimant asserts that Referee Podnar "rejected the findings of Dr. Powell and found that claimant did not have a preexisting condition at the level now complained of." Although it is not clear, we understand claimant to argue that SAIF is precluded from asserting that claimant's current symptoms are due to his preexisting conditions.

In the prior litigation, Referee Podnar only addressed Dr. Powell's medical opinion to the extent that his objective findings "persuasively indicate that claimant injured himself at [the midback] level on February 27, 1992." (Ex. 20-3). As SAIF asserts, Referee Podnar did not find that claimant's preexisting low back conditions had resolved; rather, he found that claimant's midback strain was a discrete injury, separate from his preexisting low back conditions, requiring only proof of material causation to establish compensability. Therefore, inasmuch as Referee Podnar did not find that claimant's preexisting conditions had resolved, SAIF is not precluded from litigating contribution of such conditions to claimant's current symptoms. See North Clackamas School Dist. v. White, 305 Or 48, 53 (1988).

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). A claimant must be medically stationary from all compensable conditions before the claim is properly closed. Rogers v. Tri-Met, 75 Or App 470 (1985); Mary J. McKenzie, 44 Van Natta 2301, 2303 (1992). It is claimant's burden to establish that he was not medically stationary. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). Whether or not claimant was medically stationary is primarily a medical question. Harmon v. SAIF, 54 Or App 121, 125 (1985).

On July 23, 1992, Dr. Powell (orthopedist) examined claimant at the request of SAIF. (Ex. 19). Dr. Powell diagnosed claimant with "possible dorsolumbar strain, related to the February 27 1992, injury and resolved." (Ex. 19-6). Based upon this medical opinion, claimant was declared medically stationary. (Ex. 29-3).

Claimant contends that the preponderance of medical evidence establishes that his accepted midback strain was not medically stationary as of July 23, 1992. Claimant essentially argues that the Referee erred in finding the medical opinion of Dr. Powell more persuasive than the opinions of claimant's treating physician, Dr. Viavant (family practitioner), and Dr. Hanscom, M.D.

Dr. Hanscom examined claimant on November 30, 1992. (Ex. 27). Dr. Hanscom opined that claimant exhibited "a classic profile of a long-term chronic pain patient," and recommended that he be sent to a pain clinic as soon as possible. (Ex. 27-2). However, Dr. Hanscom failed to address the relationship between claimant's current symptoms and his 1992 midback strain. Nor did Dr. Hanscom discuss the relative contribution of claimant's preexisting back condition with regard to his current complaints. Consequently, we find Dr. Hanscom's medical opinion to be inadequately explained regarding the causation of claimant's current condition. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

On December 29, 1992, Dr. Viavant concurred with Dr. Hanscom's recommendations and opined that claimant was suffering from "debilitating back pain" precluding him from "even light duty work." Dr. Viavant stated that "evaluation and treatment at the pain clinic would enable him to return to at least light duty work or pursue vocational rehabilitation more successfully." (Ex. 28). In a February 8, 1993 letter to SAIF, Dr. Viavant opined that claimant's February 1992 injury is the major cause of his current midback condition. (Ex. 30-2). However, Dr. Viavant also stated that his opinion was predicated on claimant's history of "good resolution of his back pain after his previous back surgeries." (Ex. 30-2).

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find persuasive reasons not to defer to Dr. Viavant's medical opinion.

The record reflects that claimant was treated for back pain thirteen times during the latter half of 1991. (Ex. 19-3). However, Dr. Viavant was under the impression that claimant's previous back problems had resolved subsequent to his back surgeries in 1988 and 1989. (Ex. 30-2). Moreover, Dr.

Viavant did not treat claimant until ten months after his February 1992 injury. Dr. Viavant only examined claimant twice more thereafter. (Ex. 30-1). Medical opinions based on incomplete or inaccurate information are not afforded persuasive force. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Inasmuch as Dr. Viavant did not base his reasoning on an accurate history, we find his opinion unpersuasive.

Furthermore, we agree with the Referee that this case involves expert analysis rather than expert external observation. Accordingly, Dr. Viavant's status as 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). Instead, we find the medical opinion of Dr. Powell to be complete, well-reasoned, and therefore most persuasive. Somers v. SAIF, supra. Thus, we conclude that claimant failed to show that he was not medically stationary at claim closure and his claim was not prematurely closed.

Aggravation

We adopt and affirm that portion of the Referee's order that upheld SAIF's denial of claimant's aggravation claim for his accepted February 27, 1992 midback strain.

Attorney Fees

The Referee found that SAIF's failure to timely provide discovery of two exhibits was unreasonable. Finding that there was no compensation due upon which to base a penalty award under ORS 656.262(10), the Referee awarded claimant an assessed attorney fee pursuant to ORS 656.382(1).

The two exhibits, Exhibits 22A (chartnotes from Doug Brown, ARNP) and 25A (Mr. Brown's reply to a check-the-box letter authored by a SAIF paralegal, Mr. Cleland) were both received by SAIF in November 1992, but were not disclosed to claimant until February 22, 1993. Since claimant had an ongoing request for discovery pursuant to filing a September 4, 1992 Request for Hearing, SAIF's delay of approximately three months was a violation of OAR 438-07-015(2).

SAIF contends that the Referee erred in awarding an attorney fee under ORS 656.382(1) because there were no amounts "then due" (i.e., all compensation on claimant's injury claim had been paid). SAIF relies on Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), where the court held that an attorney fee award was improper because the employer had paid the entire award of compensation prior to the discovery violation and, thus, the employer did not unreasonably resist the payment of compensation.

Although we agree with the Referee's finding that SAIF failed to comply with discovery requirements of OAR 438-07-015(2), we do not agree that SAIF's failure to timely provide discovery amounted to an unreasonable resistance to the payment of compensation under ORS 656.382(1). The record does not establish that any compensation was unpaid at the time of the discovery violation.[1] Moreover, the Referee affirmed the Order on Reconsideration, upheld SAIF's aggravation denial, and declined to award interim compensation.

Under such circumstances, there was no unreasonable resistance to the payment of compensation that would allow for the assessment of an attorney fee under ORS 656.382(1). See SAIF v. Condon, 119 Or App 194 (1993); Aetna Casualty Co. v. Jackson, supra. Consequently, we reverse that portion of the Referee's order that awarded claimant's counsel an assessed attorney fee.

ORDER

The Referee's order dated December 8, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that awarded claimant's counsel an assessed attorney fee is reversed. The remainder of the Referee's order is affirmed.

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[1] We note that Exhibit 31A (claimant's account balance with a Washington medical center) reflects charges for medical services billed to "wkms comp" beginning October 16, 1992. Inasmuch as there is no evidence when the billing was mailed, claimant cannot rely upon the presumption of receipt under ORS 40.135(1)(q). Consequently, we are unable to determine if SAIF unreasonably resisted the payment of those charges. See Carol M. Cote-Williams, 44 Van Natta 367, 369 (1992).

In the Matter of the Compensation of
DONALD D. HILLIARD, Claimant
WCB Case No. 93-15330
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Lipton's order that affirmed a Director's order dismissing claimant's request that the Director review his eligibility for vocational assistance. On review, the issue is vocational assistance.

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

The Director cited Harsh v. Harsco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994), for the proposition that there is no statutory authority for vocational benefits for those claimants, such as claimant in the present case, whose aggravation rights have expired. However, the Director dismissed the case "because the issue of entitlement to benefits under the Board's Own Motion is outside the jurisdiction of the Workers' Compensation Division."

Also relying on Harsh, supra, the Referee determined that the Director's order was correct on substantive grounds, regardless of whether it was correct on jurisdictional grounds. On review, claimant argues that, because the Director's order dismissed the case on jurisdictional grounds, it did not reach the substantive grounds. Relying on our decision in David F. Meissner, 45 Van Natta 249 (1993), claimant argues both that the Department has jurisdiction over this dispute and that he is substantively entitled to vocational assistance.

We agree with claimant that the Director has jurisdiction to decide claimant's likely eligibility for vocational benefits. Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992).

Here, ORS 656.283(2) authorizes the Director to decide the issue in dispute, i.e., claimant's potential eligibility for vocational assistance. The fact that a claimant may not be entitled to such services due to the own motion status of his or her claim does not deprive the Director of jurisdiction to make that determination.

However, we disagree with claimant that he is substantively entitled to vocational assistance. Meissner, supra, held that claimants are not disqualified from vocational assistance under ORS 656.340 merely because their aggravation rights have expired. Claimant argues that Meissner is still viable, regardless of the court's decision in Harsh, because Meissner interpreted ORS 656.340, whereas Harsh interpreted ORS 656.278(1).

However, subsequent to the Referee's order and the parties' briefs on review, the court reversed our decision in Meissner. All American Air Freight v. Meissner, 129 Or App 104 (1994). The court reversed per curiam, citing Harsh, supra. Thus, the court apparently rejected our reasoning in Meissner and relied on its conclusion in Harsh that there is no statutory authority for vocational benefits for "own motion" claimants. Walter C. Windom, 46 Van Natta 1559 (1994).

We are constrained to follow the court's holding in Harsh and Meissner. Accordingly, because claimant's claim is in "own motion" status, he is ineligible for vocational assistance.

ORDER

The Referee's order dated April 7, 1994 is affirmed.

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
SECOND ORDER ON REMAND
Craine & Love, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

On August 10, 1994, we withdrew our July 29, 1994 Order on Remand which affirmed a Referee's order that awarded claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right forearm. We took this action to consider claimant's contentions that we erred in declining to consider the impairment findings from Dr. Johnson because the record did not establish that Dr. Johnson was licensed to practice medicine in the State of Oregon. Having received the insurer's response, as well as claimant's reply, we proceed with our reconsideration.

In our reconsideration order, 46 Van Natta 1563 (1994), on remand from the Court of Appeals, Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994), we held that an "out-of-state" physician who was not licensed to practice medicine within the state of Oregon was not included within the definition of "attending physician" under ORS 656.005(12)(b)(A) and, thus, the physician's impairment findings could not be considered in rating the extent of claimant's permanent disability. Finding that the record as presently developed did not establish that Dr. Johnson was licensed to practice medicine in the State of Oregon, we concluded that Dr. Johnson's impairment findings could not be used in rating the extent of claimant's permanent disability.

Inasmuch as there were neither medical arbiter findings nor findings from an "attending physician," we held that claimant had not established entitlement to permanent disability. However, since the insurer did not seek reduction of claimant's award, we declined to reduce the Referee's 34 percent scheduled permanent disability award for loss of use or function of the right forearm.

Raising essentially two objections to our conclusion that Dr. Johnson's impairment findings cannot be considered, claimant seeks reconsideration. First, she asserts that Dr. Johnson's status as an "attending physician" was not challenged at hearing and, therefore, such a "defense" cannot be "raised" on appeal. Secondly, based on a "post-hearing" report from Dr. Johnson (which contains a hand-written notation stating that "I am licensed in Oregon as well! #14417"), and claimant's counsel's recent "confirmation" of such information through a call to the Oregon Board of Medical Examiners, claimant requests remand for consideration of such evidence.

In response to claimant's request, the insurer submits a written statement from the Oregon Board of Medical Examiners which concurs with the insurer's understanding that Dr. Johnson's license has been inactive since the beginning of 1988. The statement further provides that Dr. Johnson cannot practice in Oregon without obtaining a certificate of active registration pursuant to ORS 677.172(3). Urging the Board to consider this "additional information," the insurer argues that Dr. Johnson is not an "attending physician" because he is not licensed to practice in the State of Oregon.

Claimant has replied to the insurer's contentions. Noting that the phrase "licensed to practice" is contained only in ORS 656.005(12)(a), claimant reasons that the relevant statute (section 12(b)) merely requires that the physician be "licensed." Inasmuch as Dr. Johnson is "licensed," claimant reasserts her prior contention that he qualifies as an "attending physician." Finally, claimant challenges the constitutionality of the statute to the extent that it denies medical treatment to out-of-state claimants.

We need not resolve the "license," "remand," and "constitutionality" arguments presented by the parties because we find that the insurer's objection to Dr. Johnson's status as claimant's "attending physician" was not timely raised. We base our conclusion on the following reasoning.

Dr. Johnson, a Washington physician, began treating claimant in December 1988. (Ex. 5). The insurer registered no objection to Dr. Johnson's status as claimant's attending physician. In fact, in May 1990, the insurer sought Dr. Johnson's response to a medical report generated by Dr. Nathan (a physician who had performed an examination on behalf of the insurer). (Ex. 20). In October 1990, Dr. Johnson also provided a report to the insurer concerning claimant's physical limitations. (Ex. 21).

At hearing, claimant offered a medical report from Dr. Johnson, which included impairment findings regarding claimant's lost grip strength and sensory deficit. (Tr. 1, Ex. 22). The insurer did not object to the submission of the report on the basis that Dr. Johnson was not claimant's treating physician. In fact, it was the insurer's position that Dr. Johnson (as claimant's treating physician) had rated claimant's impairment pursuant to his prior concurrence with Dr. Nathan's report. (Tr. 4).[1]

During opening argument, claimant's counsel also contended that, based on the report from claimant's "treating doctor Ellis Johnson" (Ex. 22), claimant was seeking a permanent disability award for strength loss, sensory loss, and a chronic condition. (Tr. 11). In response, the insurer raised no objection to Dr. Johnson's status as claimant's treating physician.

The first reference in the record documenting the insurer's "attending physician" challenge to Dr. Johnson's impairment findings is contained in the insurer's respondent's brief. In light of such circumstances, we conclude that it does not achieve substantial justice to permit the insurer to raise this "attending physician" objection to Dr. Johnson's impairment findings subsequent to the closure of the record. Such a conclusion is particularly appropriate where, as here, the insurer previously sought to rely on that same physician's concurrence with a consulting physician's findings. (Tr. 4).

Our conclusion is in keeping with this Board's longstanding policy not to consider issues which have not been raised at hearing. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). We recognize that, in a general sense, an "attending physician" issue is potentially encompassed within all extent of permanent disability disputes. Nevertheless, the introduction of that "potential" issue is entirely dependent on the parties' respective positions as articulated at the hearing.

Here, although presented with several opportunities to raise such an objection, the insurer expressed no disagreement with Dr. Johnson's status as claimant's attending physician. In fact, the insurer solicited Dr. Johnson's concurrence with a consulting physician's report and sought to rely on that concurrence as probative evidence concerning claimant's permanent impairment. Moreover, the insurer neither objected to the admission of Dr. Johnson's medical report (which contained impairment findings) on the basis that Dr. Johnson was not an "attending physician" nor did the insurer challenge claimant's express reliance on Dr. Johnson's impairment findings on the ground that Dr. Johnson was not an "attending physician."

Considering the insurer's acquiescence to claimant's implicit and explicit assertions concerning Dr. Johnson's status as her "attending physician," we decline to entertain the insurer's "post-hearing" objections to consideration of Dr. Johnson's impairment findings insofar as those objections are based on an alleged failure to satisfy the statutory definition of an "attending physician." Such a conclusion promotes the full and unimpeded presentation of issues for resolution at hearing. In other words, if a party intends to challenge a physician's status as an "attending physician" based on a lack of an Oregon license to practice, that party must register such an objection at the hearing. In this way, the parties' respective positions can be fully presented and the record completely developed.

The alternative conclusion would not advance the goals we have previously proclaimed. Rather, to permit a party to raise a "post-hearing" challenge to a physician's "attending physician" status could encourage parties to withhold such objections until they learn of the Referee's permanent disability determination. Thereafter, only when dissatisfied with the decision, they could register their objection and, in doing so, present additional procedural issues concerning "reopening of the record" and "remand." We do not wish to encourage such gamesmanship.

Furthermore, as a precautionary maneuver to offset the potential of such an "ex post facto" challenge, the party seeking to rely on an "attending physician" findings would likely be forced to resort to securing evidence regarding that physician's status as an Oregon physician in every case. Although necessary in selected cases, we do not wish to promote practices for all cases which would inevitably result in greater costs to the system and more litigation.

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[1] The insurer initially objected to the admission of Dr. Johnson's October 1990 report (Exhibit 22) on the grounds of untimely disclosure. (Tr. 1). However, that evidenciary objection was subsequently resolved when the Referee permitted introduction of that report and Dr. Nathan's November 1990 report (Ex. 23) in return for continuing the record to permit Dr. Nathan to perform another examination subject to claimant's right to cross-examine Dr. Nathan. (Tr. 10). In February 1991, following receipt of Dr. Nathan's January 1991 report (Ex. 24), the record was closed.

Our conclusion is not inconsistent with our previous reasoning regarding the meaning of ORS 656.005(12)(b)(A).[2] We adhere to our interpretation that the statute requires that an "attending physician" be licensed to practice medicine in the state of Oregon. Nevertheless, for the reasons expressed above, the insurer did not timely challenge whether Dr. Johnson satisfied that statutory requirement. Because of its silence at hearing, we consider the insurer to have effectively acknowledged that Dr. Johnson was claimant's "attending physician" (regardless of whether the record would support such a finding). Considering this concession, we are authorized to rate claimant's permanent impairment based on Dr. Johnson's findings.

Because claimant's condition became medically stationary on April 18, 1990, and her claim was closed by Notice of Closure on May 4, 1990, we apply the "standards" effective at the time of the Notice of Closure in rating claimant's permanent disability. (WCD Admin. Order 1-1989).

Dr. Johnson found a total loss of two-point discrimination in the median nerve distribution. The "standards" allow for a 40 percent award for complete loss of sensation in the median nerve distribution. Former OAR 436-35-110(1)(c). Accordingly, claimant is entitled to a 40 percent award under this rule.

Dr. Johnson reported a 30 percent reduction in grip strength due to atrophy. Thus, claimant is entitled to an award for decreased grip strength due to atrophy. Former OAR 436-35-110(3)(d) provides for an award of 15 percent for claimant's 70 percent retained grip strength in her forearm.

Former OAR 436-35-010(7) provides for a 5 percent disability award for chronic conditions which limit repetitive use of a scheduled body part.

Here, Dr. Johnson noted that physically demanding work or repetitive wrist motion will quickly lead to surgical intervention. Dr. Johnson also restricted claimant to sedentary work with limited wrist activity. Based on Dr. Johnson's opinion, we find that claimant is entitled to an award of 5 percent for a chronic condition limiting repetitive use of her right forearm.

Combining 40 percent impairment for complete loss of sensation in the median nerve distribution with 15 percent impairment for decreased grip strength due to atrophy yields an impairment of 49. Combining 49 with the 5 percent award for a chronic condition yields a total of 52 percent. Accordingly, under the standards, claimant is entitled to 52 percent scheduled permanent disability. Therefore, we increase claimant's scheduled permanent disability award for loss of use or function of the right forearm from 34 percent, as granted by the Referee's order, to 52 percent.

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[2] Our decision is likewise not inconsistent with our holding in Gary C. Fischer, 46 Van Natta 221 (1994). In Fischer, we adhered to our previous decision, 46 Van Natta 60 (1994), which had found that a "post-reconsideration order" report from the claimant's attending physician was not relevant in determining the extent of the claimant's permanent disability because the report did not establish that it was addressing the claimant's condition as of the date of the reconsideration order as required by ORS 656.283(7). In doing so, we denied the claimant's motion to remand for the submission of a "post-hearing" report from the claimant's attending physician because we found that the report was obtainable with due diligence at the time of hearing. We further reasoned that such a relevancy determination was mandated by ORS 656.283(7), regardless of whether specifically raised by the parties.

Here, in contrast to Fischer, we have found that the insurer's silence to claimant's implicit and explicit reliance on Dr. Johnson's impairment findings as claimant's treating physician constitutes a concession that Dr. Johnson was an "attending physician." Thus, considering this acknowledgment, we are entitled to consider Dr. Johnson's impairment findings in rating the extent of claimant's impairment findings. In the absence of such an acknowledgment or concession, we would be mandated to determine whether Dr. Johnson satisfied the statutory definition of an "attending physician."

Likewise, had the parties in Fischer acknowledged or conceded that the "post-reconsideration order" report addressed the claimant's condition as of the date of the reconsideration order, we would have given that report probative weight in determining the extent of the claimant's permanent disability. However, in the absence of such an acknowledgment or concession, we were obligated to evaluate the relevancy of the report in light of ORS 656.283(7).

In a case in which a claimant finally prevails in respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). Here, claimant has finally prevailed on the extent of disability issue. Therefore, claimant is entitled to a reasonable attorney fee for services concerning the issue before the Board and the Court of Appeals.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the Board and court levels concerning the extent of claimant's scheduled permanent disability is $4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs to the Board and court), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant's attorney is also receiving an attorney fee from claimant's increased compensation created by this order.

Accordingly, on reconsideration, the Referee's order dated March 11, 1991 is modified. In addition to the Referee's award of 34 percent (51 degrees), claimant is awarded 18 percent (27 degrees) scheduled permanent disability, giving her a total award to date of 52 percent (78 degrees) scheduled permanent disability for loss of use or function of the right forearm. Claimant's attorney is awarded 25 percent of the additional compensation awarded by this order not to exceed $3,800. In addition, claimant's attorney is awarded $4,000, payable by the insurer for services before the Board and court.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

For the reasons expressed in my previous dissent, I continue to interpret the statutory scheme in a manner that would include an out-of-state physician (medical doctor, doctor of osteopathy, or oral surgeon) within the term "attending physician" for purposes of rating a claimant's permanent impairment. However, since my fellow members continue to adhere to that conclusion, I am bound to follow it.

I write separately to register my agreement with the majority's determination that the insurer is now precluded from challenging Dr. Johnson's status as an "attending physician" because it did not object to claimant's reliance on Dr. Johnson's impairment findings on an "attending physician" basis at the time of the hearing. I submit that, to do otherwise, holds this claimant (and potentially future claimants) hostage to "post-hearing" objections from carriers challenging the status of a particular physician's license. Because such questions inevitably divert us from our primary responsibility of adjudicating claims, I suggest that this Board should leave such "license" matters to other boards who are authorized to resolve such matters.

Board Chair Neidig specially concurring.

I continue to adhere to the majority's conclusion in its initial Order on Remand which holds that an "out-of-state" physician who is not licensed to practice medicine in the state of Oregon does not satisfy the definition of "attending physician" under ORS 656.005(12)(b)(A). However, where, as here, a carrier does not lodge a challenge to a physician's status before or at a hearing regarding the extent of permanent disability, I agree with the majority's reasoning that a carrier has essentially conceded claimant's physician's status as an "attending physician."

The message from this decision should be interpreted in the following manner. If a workers' compensation carrier wishes to challenge a particular physician's status as an "attending physician," that carrier should raise that question at or before the hearing regarding the extent of the claimant's permanent disability. When raised in such a manner, resolution of the question can be reached based on a fully developed record with full notice to all interested parties.

In the Matter of the Compensation of
THOMAS R. LEE, Claimant
WCB Case Nos. 93-02711 & 92-15814
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Moscato, et al., Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Norman Marshall, a noncomplying employer, requests review of that portion of Referee Menashe's order that dismissed his 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. In his brief, Marshall also seeks to limit the admissibility of an exhibit. On review, the issues are evidence and jurisdiction. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Marshall contends that the only document offered and received as Exhibit 99 was a postal return receipt showing a date of delivery of October 16, 1992. We are unsure of the nature of Marshall's objection. We agree, however, that only the October 16, 1992 postal receipt constitutes Exhibit 99. The other pages marked "Exhibit 99" are duplicative of the noncompliance order which was previously admitted into the record as Exhibit 78.

Jurisdiction

We adopt and affirm the Referee's reasoning and conclusion, with the following comments.

On August 24, 1992, the Workers' Compensation Division issued a Proposed and Final Order finding Marshall to be a noncomplying employer. On that same date, the Division referred claimant's low back injury claim to SAIF for processing as required by ORS 656.054. On August 25, 1992, the Division mailed a certified letter containing the noncompliance order, copy of the Division's referral to SAIF, and "Important Notice to Alleged Noncomplying Employer" to Marshall at his residence. The notice advised Marshall that if he wished to object to claimant's claim, his request for hearing must be received by the Board within 90 days of the date the Division referred the claim to SAIF for processing.

The Post Office attempted to deliver the letter to Marshall on August 28 and September 2, 1992. The Post Office returned the "unclaimed" letter to the Division on September 13, 1992. The Division remailed the certified letter with enclosures to Marshall at his residence on September 28, 1992. Marshall signed for the letter on October 16, 1992.

Marshall filed a request for hearing contesting the compensability of claimant's low back condition claim on December 9, 1992. The Referee dismissed Marshall's hearing request as not timely under ORS 656.054.[1] Marshall appealed to the Board.

A noncomplying employer has 90 days after a claim is referred to SAIF by the Division to request a hearing objecting to the claim. ORS 656.054; ORS 656.262(6); Thomas R. Lee, 46 Van Natta 69 (1994). In our prior order, we were unable to determine if in fact Marshall had received "notice" from the Division. Specifically, the record did not establish that the Division's letter contained the required notice to noncomplying employers or that Marshall had received the Division's letter. As the jurisdictional issue was dependent on Marshall having received proper notice from the Division, we remanded this matter to the Referee to obtain additional evidence.

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[1] ORS 656.054 provides in pertinent part that: "At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim." ORS 656.262(6) provides in pertinent part that: "Written notice of acceptance or denial of the claim shall be furnished to the claimant . . . within 90 days after the employer has notice or knowledge of the claim."

Relying on the testimony of Workers' Compensation Division Field Representative Repp, the Referee found that the required notice was included in the certified letter mailed to Marshall. The Referee further found, as supported by a postal return receipt, that Marshall received the notice on October 16, 1992. The Referee therefore republished his order dismissing Marshall's hearing request as untimely.

On review, Marshall argues that there is no "direct" evidence that the Division sent him the required notice. Persuasive evidence need not be direct; it may be circumstantial. See Austin v. SAIF, 35 Or App 249 (1978); Louis R. Orman, 43 Van Natta 226 (1991). Following our de novo review of the record, we find persuasive the testimony of Field Representative Repp regarding the normal practice of the Division concerning documents sent to an alleged noncomplying employer. Accordingly, the preponderance of the evidence establishes that the required notice was included in the Division's certified letter received by Marshall on October 16, 1992.

Marshall also contends that he had 90 days from receipt of the notice from the Division in which to request a hearing. We disagree. ORS 656.054 and ORS 656.262(6) mandate that SAIF, as the statutory claims processing agent for noncomplying employers, accept or deny claims within 90 days of referral by the Division, just as insurers for complying employers must accept or deny claims within 90 days after the employer has notice of the claim. ORS 656.054 further provides that a noncomplying employer may request a hearing objecting to a claim within the 90-day period SAIF has to accept or deny the claim. See ORS 656.262(6); Thomas R. Lee, supra.

Here, the Division referred the claim to SAIF on August 24, 1992. Therefore, the 90-day period within which SAIF could accept or deny the claim, or within which Marshall could request a hearing objecting to claimant's claim, ran through November 22, 1992. Consequently, the Referee did not err in dismissing Marshall's December 9, 1992 request for hearing as not timely filed.

ORDER

The Referee's order dated April 12, 1994 is affirmed.

October 28, 1994 Cite as 46 Van Natta 2270 (1994)

In the Matter of the Compensation of
JERRY B. MATHEL, Claimant
WCB Case No. 90-18752
ORDER OF ABATEMENT
Rasmussen & Henry, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Pursuant to our October 6, 1994 Order on Remand, we affirmed a Referee's order which had set aside the self-insured employer's denial of claimant's myocardial infarction claim. In accordance with the Supreme Court's appellate judgment, we also awarded an employer-paid attorney fee of $23,250.

The employer requests reconsideration. Enclosing motions and responses which have been directed to the Supreme Court concerning claimant's attorney fee award, the employer seeks abatement of our order until such time as the Supreme Court addresses the employer's "Motion to Recall and Amend Appellate Judgment." Claimant has responded to the motion, asserting that issuance of our Order on Remand has effectively rendered this attorney fee matter moot.

Inasmuch as this is our first notice of the existence of the pending motion before the Supreme Court and since the Court has apparently not yet addressed the motion, we consider it appropriate to withdraw our order. In order to keep us fully advised of further actions regarding this case, the parties are directed to provide us with copies of any correspondence between them and the Court. Upon receiving notice of the Supreme Court's decision regarding the employer's motion, we shall expeditiously proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA D. MILES, Claimant
WCB Case No. 93-09724
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Referee Daughtry's order which set aside its denial of claimant's consequential fibromyalgia claim. On review, the issue is compensability.

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

Claimant sustained compensable low back and right ankle injuries as a result of a slip and fall injury on or about December 28, 1992. Dr. Meyers, the initial attending physician, diagnosed fibromyalgia in March 1993, based on his identification of 20 trigger points on claimant's body. Claimant's fibromyalgia was later denied by the insurer.

The Referee found that claimant's fibromyalgia was compensable under ORS 656.005(7)(a)(A) and set aside the insurer's denial. The Referee relied on the medical opinion of the current treating physician, Dr. MacKinnon, a rheumatologist, who opined that claimant's original injury was an indirect but major contributing cause of claimant's fibromyalgia. On review, the insurer contends that the medical opinions of Dr. Meyers and a consulting rheumatologist, Dr. Kappes, are more persuasive.

Both claimant and the insurer agree that the fibromyalgia condition is compensable, if at all, as an indirect consequence of the compensable low back and right ankle injury. Accordingly, claimant must establish that the original injury is the major contributing cause of the fibromyalgia disorder. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

We generally defer to the opinion of the attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). However, where the medical causation issue involves a question of expert analysis rather than expert observation, the attending physician's opinion is not accorded special deference. See Allie v. SAIF, 79 Or App 284 (1986).

The insurer contends that this is a case of expert analysis rather than expert external observation; therefore, it asserts that the Referee erred in deferring to the attending physician, Dr. MacKinnon. However, even assuming that the insurer is correct, we agree with the Referee that Dr. MacKinnon's medical opinion is the most persuasive on this record.

Dr MacKinnon wrote the following concerning the causation of claimants' fibromyalgia:

> "***I think this may have to do with the deconditioning that comes from the inactivity that results from a localized muscle injury. Frequently people are taken off work and have inactivity advised to them. Frequently depression occurs as a result of not working due to the decreased income and/or weight gain, and generalized fibromyalgia results.
>
> If the patient had no evidence of pre-existing fibromyalgia, I would have to say that her fibromyalgia was in major part the result of her original injury in December of '92. As discussed above, this would not be a direct result of the injury but more an indirect result of the injury." (Ex. 27).

Dr. MacKinnon's opinion is supported by the unrebutted evidence presented by claimant. Claimant testified to symptoms of depression for which she was prescribed medication by Dr. MacKinnon. (Tr. 9). Dr. MacKinnon's chart notes verify this testimony. (Ex. 21A). Claimant has also experienced weight gain as well as decreased income. (Trs. 7,8; Exs. 19A, 22). Moreover, there is no evidence of preexisting fibromyalgia. In light of these factors, we find Dr. MacKinnon's opinion to well-reasoned and persuasive. In addition, we find Dr. MacKinnon's opinion more cogent than the opinions of Dr. Kappes and Dr. Meyers.

Dr. Kappes agreed that claimant has objective evidence of fibromyalgia, but wrote that the cause of this disorder is unknown. (Ex. 23). He listed sleep disturbance and lack of physical fitness, both of which pertain to this claimant, as theoretical causes of fibromyalgia. Dr. Kappes concluded that "I find no logic to why it would be work related after this long period of time of not working. There has to be other mechanisms for ongoing pain, as described above." (Ex. 23).

We do not find Dr. Kappes' opinion to be very convincing, given the lack of explanation of his opinion. Moreover, Dr. Kappes seems to imply that sleep disturbance and deconditioning may be responsible for claimant's ongoing pain, but does not explain why the fibromyalgia is not work related when claimant's sleep disturbance and lack of fitness appear to have resulted from her injury. In contrast, Dr. MacKinnon's explanation of the causal nexus between claimant's fibromyalgia and her compensable injury makes sense in light of the evidence presented in the claim.

Finally, Dr. Meyers' opinion suffers from the same defect that mars Dr. Kappes' opinion, which is the lack of a cogent explanation of why claimant's condition is not work related. In April 1993, Dr. Meyers concluded that claimant's pain "is no longer related to any injury sustained in the workplace" and that the diagnosis of fibromyalgia and accompanying pain "do not in any way reflect a work-related injury." (Ex. 14). Without providing any reasoning to support his opinion, we do not accord much weight to Dr. Meyers' medical opinion. Therefore, we find Dr. MacKinnon's opinion to be more persuasive.

In conclusion, we agree with the Referee that claimant has sustained her burden of proving that her fibromyalgia disorder is a compensable consequence of her accepted injury. ORS 656.005(7)(a)(A). Thus, the Referee correctly set aside the insurer's denial.

Claimant's counsel is entitled to attorney fees for services on 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 assessed attorney fee for claimant's counsel's services on review regarding the compensability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief 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 may go uncompensated.

ORDER

The Referee's order dated April 11, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ROY E. SHELL, Claimant
WCB Case No. 93-14749
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee McWilliams' order that set aside its denial of claimant's occupational disease claim for a right wrist condition. Claimant has moved the Board for an order striking the employer's reply brief. On review, the issues are compensability and motion to strike. We affirm.

FINDINGS OF FACT

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

The last sentence of the section entitled "Findings of Fact" is supplemented to indicate that, on March 2, 1994, Dr. Nathan noted changes in claimant's clinical presentation, including symptoms in the right median nerve distribution and all the digits of the left hand.

CONCLUSIONS OF LAW AND OPINION

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

The employer's appellant's brief was rejected as untimely filed. Inasmuch as the employer had failed to file a timely brief, claimant declined to submit a respondent's brief. Thereafter, the employer submitted a "reply" brief and claimant moves that we strike it. Claimant's motion is granted because there is nothing to which the employer could reply. See Alvin Woodruff, 39 Van Natta 1161 (1987); Harold C. Kimsey, 39 Van Natta 1166 (1987) The employer's briefs have not been considered.

Ordinarily, claimant's attorney would not be entitled to an attorney fee for services on review because he filed no brief. See Shirley M. Brown, 40 Van Natta 879 (1988). However, the employer's action in filing its "reply brief" necessitated a response from claimant's attorney. We conclude that claimant's counsel's response constituted "legal representation" short of briefing within the meaning of ORS 656.382(2) and that a fee for services rendered in connection with that response is appropriate. See Earl E. Baughman, 40 Van Natta 1807 (1988).

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 motion to strike is $100, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the motion, as represented by the document, and the complexity of the issue.

ORDER

The Referee's order dated April 11, 1994 is affirmed. For services on review, claimant's counsel is awarded a $100 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
LAURI A. TERRELL, Claimant
WCB Case No. 93-05363
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Michael V. Johnson's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a 10 percent penalty for its allegedly unreasonable denial. In her brief, claimant requests an increased penalty. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the Referee's opinion concerning the compensability of claimant's back injury claim. In reaching this result, we rely on the opinions of Drs. Bert, Brooks, and Stanford, because we find that they are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

The Referee also found that the insurer's denial was unreasonable because all the medical evidence at the time expressly stated that claimant did sustain an injury on December 28, 1992 and did not indicate that claimant's preexisting back problems prevented the injury from being the major contributing cause of claimant's current back condition. On this basis, the Referee assessed a 10 percent penalty. We disagree.

Penalties may be assessed when a carrier unreasonably delays or unreasonably refuses to pay compensation. ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988), Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A denial is not unreasonable if that carrier "has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App (1990)).

In this case, the insurer had Dr. Daskalos' initial opinion that, although claimant had an acute lumbosacral strain, she also had a "long history" of lower back problems which "certainly play a significant role in this case." (Ex. 4-2; see also Ex. 9). Inasmuch as claimant had a preexisting back condition which contributed to her problems following the December 28, 1992 incident, the insurer was aware that claimant would probably be subject to the major contributing cause standard imposed by ORS 656.005(7)(a)(B). Considering Dr. Daskalos' opinion that claimant's (noncompensable) preexisting condition was a significant cause of back problems after her back strain, we conclude that the insurer legitimately doubted whether the incident at work was the major cause of her subsequent condition. Under these circumstances, we conclude that the insurer's denial was not unreasonable. Consequently, no penalty is assessed.

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

ORDER

The Referee's order dated April 8, 1994 is reversed in part and affirmed in part. That portion of the order that assessed a 10 percent penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $2,000 attorney fee.

In the Matter of the Compensation of
TIMOTHY L. WILLIAMS, Claimant
WCB Case No. 93-14661
ORDER OF DISMISSAL
Coons, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

The self-insured employer requested review of that portion of Referee Emerson's order that set aside its denial of claimant's L5-S1 disc herniation. Claimant moves to dismiss the employer's request for review on the ground that, after it filed the request for review, the employer formally accepted his claim. We grant the motion.

FINDINGS OF FACT

On April 12, 1994, the Referee issued an Opinion and Order setting aside the employer's denial of claimant's L5-S1 disc herniation. On April 19, 1994, the employer, through its processing agent, accepted the claim by a Notice of Acceptance. A copy of the notice was provided to claimant and his attorney. The next day, the employer requested reconsideration of the Referee's order.

On April 22, 1994, the employer issued a form "1502" stating that the April 19 acceptance had been issued in error and that the claim had been appealed through the reconsideration process. The form was copied to claimant. The Referee subsequently abated the order and, on reconsideration, adhered to the original order.

The employer requested Board review of the Referee's order. Claimant has moved to dismiss the request for review on the ground that, in view of the employer's April 19 acceptance, there no longer exists a factual or legal foundation for an appeal.

CONCLUSIONS OF LAW AND OPINION

The Court of Appeals recently addressed a similar factual scenario in SAIF v. Mize, 129 Or App 636 (1994). There, pursuant to a Board order, a carrier accepted the claimant's claim via a Notice of Acceptance; the notice did not specify that the acceptance was contingent on the carrier's right to appeal. Two weeks later, the carrier petitioned for judicial review of the Board's order. The same day, the carrier sent the claimant a letter stating that its earlier Notice of Acceptance "'was made contingent upon [its] right to appeal this case.'" 129 Or App at 638.

The claimant asserted that, in view of the carrier's acceptance, the petition for review should be dismissed. The carrier argued that it issued the acceptance notice so that the claim could be processed and that it did not intend the acceptance to terminate its appellate rights. The carrier did not argue that the Notice of Acceptance was not an acceptance or that it had been issued by mistake.

The Mize court characterized the issue as concerning the legal effect of the carrier's acceptance with regard to its right to contest the compensability of the claim. The court first concluded that a carrier is not required to accept a claim during the processing of the claim while the compensability issue is being litigated. Id. at 639.

Next, the court determined that the carrier's acceptance was clear and unqualified. Therefore, the court concluded, because the carrier had officially notified the claimant of the acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6).

Finally, the court concluded that, once the carrier had accepted the claimant's claim, the parties were not longer adverse to each other; that is, the controversy over compensability had become moot. Because addressing the merits of the carrier's petition under those circumstances would be to issue an advisory opinion, the court dismissed the petition for review. Id. at 640.

This case is markedly similar to Mize. Here, as in Mize, the employer accepted the claim by Notice of Acceptance that did not, in any way, specify that it was contingent on the employer's right to appeal. Then, several days later, the employer purported to correct or modify that acceptance by issuing a letter explaining that the Notice of Acceptance had been issued in error and that the claim had been appealed by means of the employer's motion for reconsideration. In effect, the employer was now asserting that its acceptance was contingent on its right to appeal.

We conclude that, in light of the employer's initial clear and unqualified acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6). The employer's "correction" letter did not comply with that provision. Accordingly, as did the court in Mize, we conclude that, once the employer accepted claimant's claim, the parties were no longer adverse to each other, and the controversy over compensability was rendered moot. Because an opinion issued under those circumstances would be purely advisory, we dismiss the employer's request for review.

Our decision in Janice M. Hunt, 46 Van Natta 1145 (1994) is distinguishable from the case at bar. In that case, while a referee's order was on review, the insurer issued a "Notice of Acceptance", accepting the claimant's claim as disabling. Simultaneously, the insurer notified the claimant of its intent to continue to challenge the referee's classification determination. In view of those facts, we concluded that the insurer's Notice of Acceptance was not inconsistent with its assertion on appeal that the claimant's condition was not disabling. Accordingly, we denied the claimant's motion to dismiss the request for review.

Here, unlike Janice M. Hunt, the employer issued its "correction" letter after it issued its unqualified acceptance of claimant's claim. In contrast to the present case, the acceptance notice in Hunt was issued simultaneously with the employer's statement that its action was based on the appealed referee's decision, a ruling that it was continuing to challenge. On this ground, and in light of the intervening Court of Appeals' decision in Mize, we find Hunt distinguishable.

Finally, we briefly address the employer's argument that its Notice of Acceptance was issued by "mistake." Even assuming that there is sufficient evidence that the acceptance notice mistakenly issued, under Mize, the employer still must comply with ORS 656.262(6) to revoke its initial unequivocal acceptance. Because we have already concluded that the employer's "correction" letter did not comply with that statute, we reject the employer's mistake argument.

In sum, we conclude that the employer's "post-hearing" acceptance of claimant's claim has rendered moot any controversy between the parties regarding the compensability of the claim. Accordingly, we dismiss the employer's request for Board review.

Claimant has requested an assessed attorney fee under ORS 656.382(2) for services on Board review. In Terlouw v. Jesuit Seminary, 101 Or App 493 (1990), the court declined to award a fee under ORS 656.382(2) because the carrier's appeal had been dismissed on the carrier's motion without a decision on the merits. Here, the employer argues that, if we dismiss the request for review, the appeal will have been dismissed without a decision on the merits; accordingly, it argues, Terlouw mandates that we award no fee.

Claimant asserts that Terlouw is distinguishable, because there, the carrier, rather than the claimant, requested the dismissal. Claimant also asserts that Agripac Inc. v. Kitchel, 73 Or App 132 (1985), which is cited in Terlouw, is inapposite because it concerned a dismissal of a petition for judicial review, not a request for Board review. In Kitchel, the Court of Appeals held that, because the carrier's petition for review had been dismissed on the claimant's motion without a finding "that the compensation to a claimant should not be disallowed or reduced, "the claimant was not entitled to a fee under ORS 656.382(2). Claimant urges us, in this case, to make a finding that his compensation should not be disallowed or reduced.

We decline claimant's invitation. Kitchel (as well as Terlouw) supports the proposition that, when a request for Board review is dismissed without a decision on the merits, we are without authority to award attorney fees under ORS 656.382(2). See Kenneth J. Short, 45 Van Natta 342 (1993). In Short, the employer withdrew its request for hearing on the issue of the compensability of the claimant's claim prior to hearing. Nevertheless, the referee made a finding the claimant's award of compensation had not been disallowed or reduced, and awarded the claimant a fee under ORS 656.382(2). We rejected that reasoning, concluding that the referee's "finding" that the claimant's award of compensation was not disallowed or reduced was not a finding "on the merits" of the claim and, therefore, that the referee was without authority to award attorney fees under ORS 656.382(2). Id. at 343.

Similarly, here, were we to make a "finding" on review that claimant's award of compensation was not disallowed or reduced, that "finding" would not be based "on the merits" of the claim. As such, it would not support an attorney fee award under ORS 656.382(2). Therefore, it follows that claimant is not entitled to an attorney fee under ORS 656.382(2).

Accordingly, the self-insured employer's request for review is dismissed.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

I write separately to express my belief that claimant's counsel should be entitled to an attorney fee under ORS 656.382(2) for services provided in obtaining the dismissal of the employer's request for review. The Oregon appellate courts have concluded that ORS 656.382(2) does not allow an award fee for legal services performed in response to a carrier's petition for judicial review that is dismissed on either the carrier's or the claimant's motion. SAIF v. Curry, 297 Or 504 (1984); Agripac, Inc. v. Kitchel, 73 Or App 132 (1985). While I recognize that those cases are binding on this Board, I disagree with the conclusion that ORS 656.382(2) does not authorize attorney fees for services provided in obtaining the dismissal of a carrier's request for review.

In Curry, the issue was whether, under ORS 656.382(2), a claimant was entitled to an attorney fee for work performed in response to a carrier's petition for judicial review that ultimately was denied. The court concluded that the predicate for the application of ORS 656.382(2) is a "finding" that the compensation awarded to a claimant should not be disallowed or reduced. 297 Or at 508. The court then noted that the legislative history relating to the 1983 amendments to ORS 656.382(2) reveal that the legislature "considered, but rejected, a proposal that would have allowed an award of attorney fees to a claimant's attorney who works on an appeal initiated by an employer or insurer, but which is dismissed on the employer/insurer's motion prior to a decision." 294 Or at 510 (emphasis added). On the basis of that history, and the fact that a denial of a petition for review did not constitute a "finding" that the claimant's compensation should not be disallowed or reduced, the court concluded that the claimant was not entitled to a fee under ORS 656.382(2). Id. at 509.

In Kitchel, supra, the Court of Appeals relied on Curry, and the legislative history cited therein, and concluded that, in the case of a dismissal of a carrier's petition for judicial review on a claimant's motion, no fee may be awarded under ORS 656.382(2). Again, the court's reasoning rested on the lack of a finding "that the compensation awarded to a claimant should not be disallowed or reduced." 73 Or App at 135.

I strongly disagree with the Kitchel court's reliance on the legislative history cited in Curry; that history concerned a dismissal on a carrier's, not a claimant's, motion. The distinction is patent. In the former, a dismissal occurs as the result of the efforts of the carrier's counsel, while, in the latter, dismissal follows the efforts of the claimant's counsel. In the latter case, I submit, claimant's counsel should be entitled to a fee for protecting the compensation awarded by the lower tribunal. Furthermore, I believe that, by granting a claimant's motion to dismiss, the Board has implicitly found "that the compensation awarded to a claimant should not be disallowed or reduced." 73 Or App at 135.

Lastly, to the extent that the Oregon appellate courts' interpretations of ORS 656.382(2) are logical, I believe that they flow from poorly drafted legislation. It makes no sense to me that the legislature would, on the one hand, authorize fees for a claimant's successful defense on the merits of a carrier's appeal, but, on the other hand, refuse to authorize fees for a claimant's successful pursuit of a dismissal on grounds other than the merits of the appeal. The effect of a successful defense on the merits and a successful motion to dismiss is the same: The claimant's award if compensation is neither disallowed nor reduced. Ergo, it seems only fair that, whenever a carrier's appeal is resolved in the claimant's favor, regardless of whether or not the decision is on the merits, the claimant's counsel should be entitled to a fee for the legal services that assured the claimant's victory.

This interpretation comports with the Curry court's statement of one of the purposes of ORS 656.382(2), viz., to discourage carriers from "wearing down claimants with harassing and frivolous appeals. The statute does this by providing an award of attorney fees to the claimant if the employer or insurer initiates a higher level examination of the case and does not win a reduction or elimination of the claimant's award." 297 Or at 508. That statement of purpose makes no distinction between appeals decided on their merits and those dismissed on other grounds, and I believe that none exists.

In sum, recognizing that I am bound by appellate case law in this state, I reluctantly agree that claimant is not entitled to a fee under ORS 656.382(2) for her counsel's services in obtaining the dismissal of the employer's request for review. However, were I in the position to interpret ORS 656.382(2) anew or, if necessary, to rewrite the statute to authorize fees in cases such as this, I would. For these reasons, I concur.

In the Matter of the Compensation of
CAROLINE F. WOOD, Claimant
WCB Case No. 93-09429
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Spangler's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant's last arrangement of compensation was the August 6, 1990 Stipulation. (Ex. 15). At that time, claimant was limited to light work, with a 15 pound lifting limit, and limited to occasional bending and twisting. (Ex. 11-2).

In January 1993, Dr. Tearse, treating neurologist, limited claimant to sedentary work. (Ex. 31). Claimant's reports to Dr. Tearse and other physicians regarding her physical limitations are unreliable.

In April 1993, claimant began treating with Dr. Karasek, neurologist, on referral from Dr. Tearse. (Ex. 19-1). On April 28, 1993, Dr. Karasek requested that SAIF reopen claimant's claim due to an objective worsening of her compensable condition, as evidenced by radiographic tests. (Ex. 19-3).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's compensable condition had not worsened and that she had not established a diminished earning capacity since the August 6, 1990 Stipulation, the last arrangement of compensation. We agree that the August 6, 1990 Stipulation is the baseline for determining whether claimant has established a compensable aggravation claim. Also, although we disagree with the Referee's conclusion regarding the worsening factor, we agree that claimant has not established a diminished earning capacity.

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, she 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).

There is no question that claimant's current low back condition results from the original injury and the June 1987 lumbar laminectomy and decompression surgery at L4-5 and L5-S1, which was performed as a result of that injury. All of the medical opinions acknowledge that causal relationship, including those of Drs. Stanford, orthopedist, and Brooks, neurologist, who examined claimant on behalf of SAIF. (Exs. 21-5, 24-2, 31, 32-2, 32A-7, 33-2).

Therefore, the question in this case focuses on whether claimant sustained a worsening of her compensable injury since the last arrangement of compensation and whether that worsening diminished claimant's earning capacity. In order to answer those questions, we must determine the baseline from which to measure any worsening.

The August 6, 1990 Stipulation is claimant's last arrangement of compensation. SAIF does not dispute that fact. However, SAIF notes that a subsequent Referee's order issued on June 24, 1991, and determined that claimant had not sustained a compensable aggravation at that time. (Ex. 18). Therefore, SAIF argues, issue preclusion dictates that claimant must prove a worsening since the June 24, 1991 order, rather than the August 6, 1990 Stipulation.

SAIF is not arguing that claimant's current aggravation claim is precluded by issue preclusion. In any event, such an argument would fail because claimant has established that her condition has changed so as to create a new set of operative facts that could not have been litigated at the previous hearing. Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560, rev den 309 Or 645 (1990). Instead, SAIF is arguing that issue preclusion changes the baseline for determining a worsening from the last arrangement of compensation to the last order regarding a prior aggravation claim. We disagree.

The clear language of ORS 656.273(1) states that claimant must prove a worsening "[a]fter the last award or arrangement of compensation." As the Referee found, the June 24, 1991 order did not involve extent of disability or address either an award or arrangement of compensation. Issue preclusion would prevent claimant from relitigating the determination that she had not established a compensable aggravation as of the June 24, 1991 order; however, it does not change the statutory baseline for the determination of a worsening regarding any future aggravation claims. Therefore, claimant must prove that her compensable condition has worsened since the last arrangement of compensation, which is the August 6, 1990 Stipulation. ORS 656.273(1).

Six physicians rendered opinions regarding whether claimant's compensable low back condition objectively worsened. Dr. Kitchel, orthopedist, treated claimant from October 1988 to March 1990. On June 8, 1993, he examined claimant on behalf of SAIF. (Ex. 21). He opined that, although claimant continued to have ongoing problems with back and radicular leg pain, her condition had not worsened since he last evaluated her in 1990. In making this determination, he examined claimant's current radiographic tests. He noted that a recent post-myelographic CT scan showed spinal stenosis at L4, although he "personally would not grade that as severe." (Ex. 21-4).

On October 7, 1993, Drs. Stanford and Brooks examined claimant on behalf of SAIF. They opined that claimant's low back condition had not worsened. (Ex. 32A). They also noted that they "cannot find any true objective findings of worsening except for some increase in the stenosis in the foramen at L4-5." (Ex. 32A-8). Dr. Kitchel concurred with their opinion. (Ex. 34).

Claimant began treating with Dr. Tearse, neurologist, in August 1990. She continued treating with Dr. Tearse until he referred her to Dr. Karasek, neurologist, in April 1993. (Ex. 19-1). Dr. Tearse opined that while he agreed with most of Dr. Kitchel's June 8, 1993 evaluation, he thought that Dr. Kitchel had overlooked the possibility of facet arthropathy, noting that facet changes appeared on a March 1993 MRI. (Ex. 23). Dr. Tearse ultimately opined that claimant's low back condition had materially worsened since July 1990, concluding that her facet arthropathy had progressed based on his review of her MRI and the diminished movement in her lumbar spine. (Ex. 31).

Dr. Karasek compared claimant's current myelographic CT with the one done about the time of the 1990 Stipulation and concluded that claimant had sustained a "clear-cut dramatic progression of her stenosis and facet arthropathy at [L]4-5 and [L]5-[S]1 since the myelographic evaluation in 1990." (Exs. 16, 19-3). Dr. Karasek opined that claimant's condition had worsened and that comparisons of the radiographic tests in 1990 and 1993 substantiated that worsening. (Exs. 19, 32, 33).

Dr. Karasek referred claimant to Dr. Hacker, neurosurgeon, for a second opinion. (Exs. 24, 30). Dr. Hacker noted that "[i]mportantly, the lateral view on [claimant's] myelogram from 1993 when compared to [claimant's] lateral myelogram view from 1990 shows approximately 8 mm of anterior translation of L4 on L5." (Ex. 24-2). Dr. Hacker opined that he "suspects" claimant's compensable low back condition has worsened, noting that he based this opinion on his comparison of the 1990 and 1993 myelograms, claimant's impaired range of motion, and her pain complaints. (Ex. 30). Although a "possibility" of a worsening is insufficient to meet claimant's burden of proof, Dr. Hacker's opinion supports Dr. Karasek's opinion.

The Referee found Dr. Kitchel more persuasive based on the fact that he had examined claimant before and after the last arrangement of compensation. However, we find that there are persuasive reasons not to rely on Dr. Kitchel's opinion. Neither Dr. Kitchel nor Drs. Stanford and Brooks compared the 1990 radiographic tests to the current 1993 tests. In contrast, Dr. Karasek compared the tests and, in a well-reasoned opinion, explained that claimant's condition has worsened. In addition, the opinions of Drs. Tearse and Hacker support Dr. Karasek's opinion. Furthermore, Drs. Stanford and

Brooks acknowledge that claimant has objective findings of increased stenosis, even though they inconsistently opine that her condition did not worsen. On the basis of Dr. Karasek's opinion, as supported by Drs. Tearse and Hacker, we find that claimant's low back condition pathologically worsened since her last arrangement of compensation.

However, claimant has failed to establish that the worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation. On July 28, 1989, the Oregon Pain Center determined that claimant was capable of light work, with restrictions. (Ex. 11-2). That is the last determination of claimant's work capacity prior to the August 6, 1990 Stipulation. Furthermore, the record shows that claimant's condition did not change between the Pain Center evaluation and the stipulation. (Exs. 12, 13). Therefore, we find that claimant was able to do light work with restrictions at the time of the last arrangement of compensation.

Dr. Tearse restricted claimant to sedentary work in January 1993. However, claimant has been unreliable in her reports to physicians, including Dr. Tearse, regarding what she is physically capable of doing. Therefore, we do not find Dr. Tearse's restriction to sedentary work persuasive evidence of any diminished earning capacity. Instead, based on the investigators' testimony and the surveillance video, we find claimant remained capable of light work.

Claimant testified at hearing that she had difficulty walking more than a block, standing for more than a couple of minutes, carrying anything "of any substance," or sitting for more than 10 to 15 minutes at a time. (Tr. 13-14, 18-19, 21-22, 31). These limitations are similar to those claimant reported to various physicians, including Dr. Tearse. (Exs. 16, 21-1, 32A-3, -6). Claimant testified that, after sitting 10 to 15 minutes, she had to get up and walk around or do stretching exercises because of the pain. (Tr. 20-22). She denied being able to sit for half an hour at a time. (Tr. 23). She testified that when sitting at auctions for her business she would "wiggle and squirm around" due to the pain. (Tr. 41). She also denied lifting any saddles at her tack shop. (Tr. 32-34). She testified that on her "good days" her back is stiff and sore and that it would be apparent to anyone watching her that she had problems walking. (Tr. 36).

In contrast to claimant's testimony is the testimony of two SAIF investigators, Ms. Rogers and Ms. Lundy. Ms. Rogers testified that she observed and filmed claimant on October 7, 1993 and October 9, 1993. (Tr. 57, 59). On October 7, 1993, she observed claimant getting out of her car and opening her tack shop. She testified that claimant appeared to have no trouble walking or moving. (Tr. 58-59). On October 9, 1993, she observed claimant at a tack and horse auction. (Tr. 59). She testified that claimant remained seated almost three hours straight without standing and without any appearance of pain. (Tr. 60, 65-66). The surveillance video supports Ms. Rogers' testimony that claimant was able to sit, stand, walk, and move without any stiffness, or signs of pain or other problems. (Ex. 32B). In addition, Ms. Rogers testified that she observed claimant carry her purchases, estimated to weigh about 20 pounds, for a short distance. (Tr. 62). Claimant agreed that the purchases weighed about 20 pounds but testified that they were carried most of the way to her car by another person. (Tr. 83).

In addition, Ms. Lundy testified that she went to claimant's tack shop on September 22, 1993, where claimant showed her two saddles by tipping them up so that she could see the underside. (Tr. 72, 74). Ms. Lundy estimated the saddles to weigh 35 to 40 pounds each. (Tr. 75).

Based on the credible testimony of the investigators, as corroborated by the surveillance video, we find that claimant has not reliably reported her physical limitations to the physicians. Therefore, we do not find Dr. Tearse's release to sedentary work persuasive evidence of claimant's earning capacity. Instead, we find that claimant remained capable of performing light work. Therefore, claimant has not established any diminished earning capacity since the last arrangement of compensation. Accordingly, she has not established a compensable aggravation claim.

ORDER

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

In the Matter of the Compensation of
DONALD M. HUGHES, Claimant
WCB Case Nos. 93-04254, 93-03505, 92-15986, 93-04253, 92-15805, 92-15804 & 92-08560
ORDER ON REVIEW
Douglas S. Hess, Claimant Attorney
Lundeen, et al., Defense Attorneys
Montgomery W. Cobb, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Mills' order that: (1) found that claimant's 1987 left elbow injury claim was not prematurely closed; (2) set aside Gates McDonald's responsibility denial of claimant's aggravation claim for a left elbow condition; (3) upheld Liberty Northwest's denial of claimant's "new injury" claim for the same condition; (4) declined to award penalties and attorney fees for Gates McDonald's allegedly unreasonable claims processing; (5) upheld Liberty Northwest's denial of claimant's injury claim for a left knee/left shoulder condition; and (6) declined to award penalties or attorney fees against Liberty for its allegedly untimely denial of claimant's left knee/left shoulder claim. On review, the issues are compensability, claims processing and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

The employer was self-insured until October 31, 1991. After that date, the employer was insured by Liberty Northwest.

Claimant's claim for a left elbow injury which occurred on October 9, 1987 was accepted by the self-insured employer as a new injury, not as an aggravation of the 1984 compensable left elbow injury. (Ex. 118).

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

We adopt and affirm the reasoning and conclusions of the Referee as set forth in his order.

Processing of Left Elbow Claim

We adopt and affirm the Referee's reasoning and conclusions with the following supplementation and clarification.

Both carriers conceded compensability of the left elbow condition. Thus, the only issue before the Referee was responsibility for that condition. The Referee found the employer, in its self-insured capacity, responsible for the left elbow condition as an aggravation. On review, claimant does not challenge the Referee's responsibility determination, but argues that his left elbow claim should be processed as an aggravation of his October 9, 1987 injury claim, rather than as an aggravation of his 1984 injury claim, which is currently within the Board's "own motion" authority.

We briefly recount the facts pertaining to claimant's left elbow claims. Claimant's left elbow problems began in August 1984 when he compensably injured his left elbow. He underwent left ulnar nerve transposition surgery in 1984 and the claim was closed in July 1985.

In October 1987, claimant strained his elbow at work and filed an injury claim. This claim was accepted as a new injury. In the spring of 1989, claimant had increasing numbness and weakness in his left hand and aching in the left elbow. Claimant saw Dr. Rosenbaum who suspected that the ulnar nerve was retrapped at the elbow region and that surgical exploration would be indicated if claimant desired. (Ex. 122; 123). Claimant's claim was reopened as an aggravation of the 1987 injury.

In June 1989, claimant was struck on the left elbow by wood being carried by a forklift. That claim was accepted, but was apparently not separately processed since claimant was receiving time loss benefits from the earlier claim reopening. The aggravation claim was closed by a Determination Order on June 13, 1990. In February 1991, while evaluating claimant's back injury, examining physician, Dr. Fuller commented that there was a possibility that claimant's ulnar nerve had slipped from its previously transposed position and was perched over the left medial epicondyle. (Ex. 184).

In July 1992, after returning to work, claimant's ulnar nerve condition worsened. Claimant reported to Dr. Gripekoven that he was dropping objects, could not hold soap and other items and had tingling almost constantly. Dr. Gripekoven reported that claimant had a significant interval change from 1989. Dr. Rosenbaum and Dr. Melvin both evaluated claimant in August 1992 and felt that claimant was a candidate for surgery to transpose the left ulnar nerve. In September 1992, Dr. Rosenbaum indicated that claimant had had a subjective, as well as objective, worsening of his left ulnar nerve function which was confirmed by nerve conduction velocity studies.

In October 1992, claimant was evaluated by Dr. Ochoa, a neurologist, on behalf of Gates McDonald. Dr. Ochoa opined that claimant's nerve condition had worsened and agreed that the surgery proposed by Drs. Rosenbaum and Melvin was reasonable.

Dr. Melvin performed claimant's nerve transposition surgery on January 5, 1993. He indicated that the left ulnar nerve lay over the most prominent point of the medial elbow bone where it was exposed to any blow or pressure on the inside point of the elbow. Because of this trauma, the nerve was encased in scar tissue, and was significantly narrowed. Dr. Melvin opined that, based on the position of the nerve and the amount of scar tissue around the nerve, trauma to the nerve in that position was the major contributing cause of claimant's worsened condition. (Ex. 323).

In determining whether to process claimant's left elbow claim as an aggravation of the 1984 injury claim or as an aggravation of the 1987 injury claim, claimant argues that we should apply the provisions of ORS 656.308(1). Specifically, claimant argues that his claim should be processed under the 1987 injury claim because, he contends, the 1987 injury constituted a "new compensable injury" involving the same condition that was accepted in 1984.

We agree with claimant's contention that principles of responsibility law are generally applicable in claim processing disputes such as this. Where, as here, the claimant has worked for the same employer who has been covered by the same carrier, we turn to an application of the "responsibility" principles of ORS 656.308(1) in determining under which claim the claimant's condition will be processed. David L. Large, 46 Van Natta 96 (1994); Peggy Holmes, 45 Van Natta 278 (1993).

In SAIF v. Drews, 318 Or 1 (1993), 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). For responsibility to shift from the 1984 claim to the 1987 claim, the 1987 injury must be the major contributing cause of claimant's current disability or need for treatment. In order to determine whether the 1987 injury claim constituted a "new compensable injury involving the same condition" under ORS 656.308(1), it is first necessary to determine whether the 1984 and 1987 injuries involved the same condition. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993).

The only medical evidence in the record which explicitly addresses whether the 1984 and 1987 injuries involve the same condition comes from Dr. Ochoa. Dr. Ochoa explained that claimant's condition in 1987 was different than claimant's 1984 condition. (Ex. 337-27). Dr. Ochoa explained that the diagnosis in 1987 was chronic entrapment of the ulnar nerve, whereas the diagnosis in 1984 was acute local mechanical trauma. (Ex. 337-28). Dr. Ochoa further believed that there was no ongoing disease process underlying the 1984 and 1987 injuries. (Ex. 337-29). Rather, Dr. Ochoa opined that, except for affecting the same nerve, the conditions were separate. (Ex. 337-29).

Given Dr. Ochoa's explanation, we conclude that the 1984 and 1987 injuries did not involve the same condition. Accordingly, ORS 656.308(1) is not applicable. Smurfit Newsprint v. DeRosset, supra at 372.

Because ORS 656.308(1) cannot assist us in resolving this dispute, we would ordinarily next turn to the "last injury" rule to determine responsibility. See John J. Saint, 46 Van Natta 2224 (1994). However, where actual causation with respect to a specific identifiable employer is established, it is unnecessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments to determine responsibility. See Eva R. Billings, 45 Van Natta 2142 (1993); Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-245 (1984). Here, based upon a review of the medical evidence, we conclude that application of the "last injury" rule is unnecessary because we are persuaded that the 1984 injury is the major contributing cause of claimant's condition.

Several physicians address the cause of claimant's current left elbow condition. Dr. Melvin believed that claimant's ulnar nerve had moved over from the position where it was placed in the 1984 surgery. Dr. Melvin believed that the ulnar nerve probably moved out of place within two to four weeks of the first surgery in 1984. Dr. Melvin further opined that claimant reinjured his elbow on October 9, 1987 and sustained another trauma to his left elbow in June 1989 which caused further injury to the ulnar nerve. Dr. Melvin indicated that claimant has experienced continuing symptomatology and limitations of use of his left arm and hand relating to his left ulnar nerve since his 1987 injury.

Dr. Duff, orthopedist, and Dr. Watson, neurologist, examined claimant on behalf of Liberty, in March 1993. They diagnosed claimant's left elbow condition as chronic ulnar neuropathy dating back to approximately August 1984. They believed that the major trauma to claimant's ulnar nerve occurred in 1984, with secondary episodes in October 1987 and possibly May 1989. Drs. Duff and Watson opined that claimant's left elbow condition had never entirely resolved and that it appeared to have progressively worsened since June 1989. Drs. Duff and Watson believed that claimant's left elbow complaints were the result of a cumulative occurrence of several injuries. (Ex. 328). Dr. Melvin concurred with the report of Drs. Duff and Watson. Dr. Rosenbaum also concurred.

Dr. Ochoa opined that the ulnar nerve gradually migrated from the position where it was placed in the 1984 surgery. (Ex. 337-17). Dr. Ochoa believed that it was probable that the ulnar nerve had repositioned itself by 1987. (Ex. 337-27). Dr. Ochoa opined that the biggest factor contributing to claimant's need for surgery in 1993 was the placement of the ulnar nerve on the epicondyle. Dr. Ochoa agreed that the ulnar nerve would not have been placed on the epicondyle had claimant not had the 1984 surgery.

After reviewing the medical evidence, we conclude that the August 1984 injury is the major contributing cause of claimant's left elbow condition. We reach this conclusion based on the medical opinions in the record. Dr. Melvin, the surgeon who performed claimant's 1993 surgery, believed that claimant's ulnar nerve moved out of position soon after the 1984 surgery to treat the 1984 nerve injury. Dr. Melvin indicated that, based on the position of the nerve and the amount of scar tissue around the nerve, trauma to the nerve in that position was the major contributing cause of claimant's worsened condition. Dr. Melvin concurred with the report of Drs. Duff and Watson who believed that the major trauma to claimant's ulnar nerve occurred in 1984, with secondary episodes in October 1987 and possibly May 1989. Dr. Ochoa felt that the biggest factor contributing to claimant's need for surgery in 1992 was the placement of the ulnar nerve on the epicondyle. Dr. Ochoa agreed that the ulnar nerve would not have been placed on the epicondyle had claimant not had the 1984 surgery to treat his 1984 nerve injury.

Based on these opinions, we are persuaded that the 1984 injury is the major contributing cause of claimant's current left elbow condition. Accordingly, we conclude that the claim should be processed as an aggravation of claimant's 1984 injury claim. We note that the worsening of claimant's left elbow condition in 1989 was processed as an aggravation of the 1987 injury claim. Nonetheless, our review of the record convinces us that the current worsening of the left elbow condition is a worsening of the 1984 injury and the surgery to correct that injury, rather than a worsening of the 1987 injury claim.

To summarize, after reviewing the entire record, we conclude that claimant's left elbow claim should be processed as an aggravation of his 1984 injury claim. It follows that the self-insured employer's processing of claimant's aggravation claim under the August 1984 injury claim was not unreasonable.

Compensability of Left Knee and Shoulder Injury

The Referee found that the insurer had "de facto" denied claimant's left knee condition. However, applying ORS 656.005(7)(a)(B), the Referee concluded that claimant did not sustain a compensable left knee injury on July 20, 1992. The Referee did not address compensability of a left shoulder injury. We adopt the Referee's reasoning and conclusions concerning the compensability of claimant's left knee condition with the following supplementation.

Claimant argues that, in addition to injuring his left knee, he sustained a compensable injury to his left shoulder on July 20, 1992 while Liberty insured the employer. Claimant further argues that the major contributing cause standard does not apply to his shoulder since he did not have a preexisting condition which combined with the injury. Based on the following reasoning, we conclude that claimant did not establish a compensable left shoulder injury.

Claimant reported on his claim form that he had fallen, twisting his left knee and hitting his left shoulder. (Ex. 283). Claimant was seen by Dr. Neuburg on July 20, 1992 after the incident described above. Dr. Neuburg reported that claimant had a probable knee strain with preexisting degenerative joint disease and contusion abrasion of the left shoulder with preexisting rotator cuff tendinitis. (Ex. 281). Dr. Neuburg described claimant's left shoulder injury as "a very superficial small abrasion just below the distal acromion." Id. There is no further mention in the medical reports of left shoulder problems resulting from the July 20, 1992 injury. Instead, the physicians focus on claimant's left knee and do not mention a left shoulder injury.

A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death. ORS 656.005(7). Here, although claimant had a very superficial and small abrasion on his shoulder, there is no indication that that condition required medical services or resulted in disability. In fact, based on the record, medical treatment for the July 20, 1992 injury was directed to claimant's left knee condition. Under such circumstances, claimant has not established that he compensably injured his left shoulder on July 20, 1992.

Claimant seeks penalties and attorney fees against Liberty for its allegedly untimely denial of claimant's left knee and left shoulder claim. However, because we have found claimant's condition not to be compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support an award of a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The Referee's order dated November 19, 1993 is affirmed.

October 31, 1994 Cite as 46 Van Natta 2284 (1994)

In the Matter of the Compensation of
PATRICK W. DINAN, Claimant
WCB Case Nos. 93-08631 & 93-02663
ORDER ON REVIEW
Crispin & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Mills' order which reduced the award of unscheduled permanent disability granted by an Order on Reconsideration from 23 percent (73.6 degrees) to zero. In its brief, the insurer argues that claimant did not timely file his request for reconsideration, and, therefore, the Department lacked jurisdiction to issue its Order on Reconsideration. On review, the issues are jurisdiction and extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Although the Referee stated that the insurer only accepted a thoracic and cervical strain, a lumbar strain was accepted as well. (Ex. 5). We also offer the following summary of the relevant facts.

Claimant sustained a compensable cervical, thoracic and lumbar strain on February 14, 1992 when he was involved in a motor vehicle accident. Claimant was treated at Kaiser primarily by Dr. Browning. X-rays showed preexisting degenerative changes in the cervical and lumbar spine including spondylolisthesis. These degenerative conditions were denied and, when claimant withdrew a request for hearing, the denial became final.

In August 1992, an orthopedic surgeon, Dr. Post, began treating claimant. A panel of Orthopaedic Consultants evaluated claimant on September 8, 1992 and concluded that claimant had no permanent impairment due to claimant's compensable injury, even though their examination revealed loss of range of motion. Both Dr. Post and Dr. Browning concurred with the Orthopaedic Consultants' report. A Notice of Closure was issued on October 22, 1992 which awarded no permanent disability. Subsequently, claimant filed an aggravation claim that was accepted on January 28, 1993.

On April 20, 1993, the 180th day after the Notice of Closure, claimant requested reconsideration by hand delivering a reconsideration request to the Hearings Division of the Workers' Compensation Board in Portland. The request was forwarded to the Department, but not received by the Appellate Unit until April 23, 1993, 183 days after the Notice of Closure. The Appellate Unit considered the reconsideration request to be timely and proceeded with its reconsideration.

During the reconsideration process, claimant was evaluated by a medical arbiter. Inasmuch as the claim was in open status because of claimant's aggravation claim, the Appellate Unit relied instead on the findings in the September 1992 Orthopaedic Consultants' examination, with which Dr. Post and Dr. Browning had concurred, to rate claimant's disability. Based on that report, claimant was awarded 23 percent unscheduled permanent disability in a July 9, 1993 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer contended that the request for reconsideration was untimely because the Appellate Unit did not receive claimant's reconsideration request until more than 180 days after the October 22, 1992 Notice of Closure had issued. See ORS 268(4)(b). Distinguishing Charles A. Lamere, 45 Van Natta 2214 (1993), and reasoning that there was no legal authority which required a reconsideration request to be filed with the Department rather than the Board, the Referee concluded that it was not inappropriate for the claimant to file his request for reconsideration with the Board. The Referee also noted that the October 22, 1992 Notice of Closure did not put the notice of claimant's right to request reconsideration in bold print as required by ORS 656.270.

Despite reaching the merits of the extent of disability issue, the Referee nevertheless reduced claimant's 23 percent award of unscheduled permanent disability to zero. Notwithstanding the Orthopaedic Consultants' findings of reduced range of motion, the Referee found insufficient evidence that claimant had permanent impairment due to the compensable injury.

On review, claimant contends that the Referee erred in reversing the permanent disability award in the reconsideration order. The insurer continues to assert that the Appellate Unit, and therefore the Board, lacked jurisdiction to address the extent of permanent disability issue because of claimant's allegedly untimely reconsideration request.

Addressing the timeliness issue first, we agree with the insurer that claimant's request for reconsideration was untimely. Thus, the Department and the Hearings Division lacked jurisdiction to evaluate the extent of claimant's permanent disability. Accordingly, we reverse the Referee's decision on this jurisdictional issue.

ORS 656.268(4)(e) provides that "If a worker objects to the notice of closure, the worker must first request reconsideration by the Department under this section." (emphasis added). ORS 656.268(6)(a) further provides that reconsideration is to be performed by a "special evaluation appellate unit."

ORS 656.268(4)(e) does not expressly state where a reconsideration request is to be filed. However, we examined similar issues in Barbara A. Gilbert, 36 Van Natta 1485 (1984), and in Charles A. Lamere, supra.

In Gilbert, the claimant requested a hearing on a carrier's closure of her claim, but did not request a Determination Order from the Evaluation Division prior to requesting a hearing as required by former ORS 656.268(3). We rejected the claimant's contention that her request for hearing satisfied her obligation to request a Determination Order from Evaluation Division. In reaching this conclusion, we reasoned that requesting a hearing was not a procedural remedy that was available as an alternative to requesting a Determination Order. We further determined that filing a hearing request with the Board did not satisfy the statutory obligation to request a Determination Order from the Evaluation Division. As further support, we cited Logue v. SAIF, 43 Or App 991 (1979), for the proposition that the Evaluation Division is distinct and has separate responsibilities from the Hearings Division.

Similarly, in this case, the Appellate Unit and the Hearings Division are separate and distinct entities, with substantially different statutory functions. Therefore, the filing of a request for reconsideration with the Hearings Division does not satisfy the claimant's statutory obligation to request reconsideration of a Notice of Closure from the Appellate Unit. Barbara A. Gilbert, supra.

Our reasoning in Lamere is consistent with the Gilbert holding. In Lamere, an employer requested a hearing regarding the noncomplying order of the Workers' Compensation Division by sending the hearing request to the Hearings Division of the Workers' Compensation Board in Salem. The hearing request was forwarded to the Workers' Compensation Division. Although ORS 656.740(3) requires that a request for hearing contesting an order of noncompliance be filed "with the Department" within 20 days of receipt of the notice of noncompliance, the hearing request was not received by the Division until the 23rd day after the noncompliance order was issued. The Division denied the employer's hearing request on timeliness grounds.

We affirmed the Referee's finding that the Hearings Division lacked jurisdiction to review the noncomplying order. 45 Van Natta at 2215. We reasoned that, since the Department did not receive the employer's hearing request within 20 days of the employer's receipt of the noncompliance order, the noncompliance order was final and not subject to review. We also rejected the employer's contention that he complied with ORS 656.740(1) by mailing the hearing request to the Board. We emphasized that the noncompliance notice clearly advised the employer that the request for hearing was to be filed with the Workers' Compensation Division. While both the Board and the Division were then, as now, a part of the Department of Insurance and Finance (now Department of Consumer and Business Services), we noted that the two are distinct entities with separate functions and duties for the purposes of workers' compensation law.

Here, we find Lamere to be instructive. Although this claim involves a different statute (ORS 656.268(4(e) as opposed to ORS 656.740(1)), the Lamere/Gilbert rationale is equally applicable. Just as the Workers' Compensation Division and the Board are distinct entities with separate functions and duties under the workers' compensation law, so, too, are the Board and Appellate Unit. Pursuant to ORS 656.268(6)(a), the Appellate Unit's sole function is to perform reconsiderations of Determination Orders and Notices of Closure. The Board has no statutory function in the reconsideration process.[1]

In other words, when ORS 656.268(4)(e) requires a worker to first request reconsideration "by the Department under this section," it is apparent that the Board is not a contributing entity to that statutory procedure. Moreover, while the statute does not expressly state that reconsideration requests must be filed with the Appellate Unit, that statute, read in conjunction with the reconsideration proceeding requirements of ORS 656.268(6)(a), clearly implies that they must be. The "appeal rights" provision on the Notice of Closure is also consistent with the statutory scheme in that it states that reconsideration must be requested "by the Appellate Unit of the Department of the Department of Insurance and Finance, Labor and Industries Building, Salem, Oregon 97310."

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[1] We are mindful of ORS 656.712, which provides that the Workers' Compensation Board "is created within the department." However, that statute concerns matters such as membership, appointment and qualifications of Board members. Therefore, it is not directly relevant to the issue at hand. This is particularly the case where, as here, there is a specific statutory procedure designed to resolve this particular dispute and sole responsibility for conducting that statutory procedure rests with the Department. See ORS 656.268(4)(e),(6).

We find further support for our conclusion in the applicable administrative rules. OAR 436-30-050(1) provides that a Notice of Closure or Determination Order will be reconsidered by the Appellate Unit "upon receipt by the Department" of a request for reconsideration. OAR 436-30-050(6) also provides that "upon receipt of a request for reconsideration, the Appellate Unit will advise all parties of the date the request was received, and the date the record will close." (emphasis added). "Department" is defined as the Department of Insurance and Finance (now Department of Consumer and Business Services). OAR 436-30-005(3). "Appellate Unit" is defined as the Appellate Unit for the Department of Insurance and Finance (now Department of Consumer and Business Services). OAR 436-30-005(2). The definitional rules of Division 30 do not include a definition of the Board, further confirming the Board's lack of involvement in the reconsideration proceeding.

In light of our examination of relevant case law, statutes and administrative rules, we conclude that filing a reconsideration request with the Board is an inappropriate means by which to request reconsideration of a Notice of Closure. Thus, we find that claimant's filing of a request for reconsideration with the Board on the 180th day does not constitute a timely reconsideration request. Accordingly, the Department and, consequently, the Board lack jurisdiction to review the October 1992 Notice of Closure.[2]

Alternatively, even if claimant's reconsideration request were timely, we would adopt and affirm the Referee's finding that claimant is not entitled to an award of permanent disability for the reasons given in his order. Thus, we would still reinstate the October 1992 Notice of closure on the merits.

ORDER

The Referee's order dated January 28, 1994 is reversed in part and affirmed in part. That portion which determined that claimant's request for reconsideration was timely is reversed. The October 22, 1992 Notice of Closure is reinstated and affirmed. The remainder of the Referee's order is affirmed.

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[2] Although the notice of claimant's appeal rights relative to the Notice of Closure was not entirely in boldfaced type as required by ORS 656.270, the words "Appellate Unit" and "Department of Insurance and Finance, Labor and Industries Building" were in such type. Moreover, as the insurer points out, there is no indication that claimant was mislead by the insurer's notice. The request for reconsideration, prepared by claimant's attorney, was addressed to the Appellate Unit at the Workers' Compensation Division.

Board Member Hall specially concurring.

Considering the labyrinth-like appellate process that the parties must follow when challenging a Notice of Closure, it is understandable that a party might not appreciate the distinction between the Appellate Unit for the Workers' Compensation Division of the Department of Consumer Business Services and the Hearings Division for the Workers' Compensation Board. Consequently, I find it difficult to disagree with the Appellate Unit's determination that the filing of claimant's request for reconsideration with the Hearings Division constituted filing with the Department.

Nevertheless, in light of the statutory scheme, there is unquestionably a delineation of functions between the Appellate Unit of the Department and the Hearings Division for the Board. Therefore, based on the reasoning expressed in the majority opinion, I must regrettably reach the conclusion that the 180-day appeal period from a Notice of Closure or Determination Order is not tolled until a party files a request for reconsideration with the Department. To reach any other conclusion would be inconsistent with the statutory reconsideration process, as well as the case precedent on similar "filing" questions. Finally, a contrary decision would undoubtedly cause further uncertainty concerning the appropriate approach to follow when appealing a Department decision.

Based on the foregoing reasoning, I specially concur.

In the Matter of the Compensation of
KATHLEEN F. GONZALEZ, Claimant
WCB Case No. 94-01937
ORDER ON REVIEW (REMANDING)
Gatti, Gatti, et al., Claimant Attorneys
Vera Langer (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Brazeau's order that dismissed her request for hearing from a Notice of Closure. On review, the issue is dismissal. We reverse and remand.

The Referee issued an order dismissing claimant's hearing request for lack of subject matter jurisdiction because the request was prematurely filed. The Referee did not convene a hearing, admit any evidence into the record, or take any testimony. Claimant requested Board review from the Referee's order of dismissal.

The following procedural history appears from the parties' allegations and briefs on review.

SAIF issued a Notice of Closure on June 16, 1993, and claimant timely requested reconsideration. On November 22, 1993, the Appellate Review Unit advised the parties that reconsideration would be stayed pending the Director's determination of whether the disability standards are adequate for rating claimant's impairment.

On February 14, 1994, claimant filed a request for hearing, appealing the Notice of Closure. SAIF moved to dismiss claimant's hearing request for lack of jurisdiction, and the Referee granted the motion. As of the date of SAIF's motion, the Order on Reconsideration had not yet issued.

On review, claimant contends that the Department had no authority to issue a notice postponing the reconsideration process in order to refer the matter to a medical arbiter. Claimant argues that, since the Department's failure to act within the statutory time limits set forth in ORS 656.268(6)(a) constitutes a denial of the reconsideration request, she is entitled to request a hearing on the Notice of Closure. Therefore, she contends that the Referee should have addressed the merits of her hearing request, and she requests remand for that purpose.

SAIF contends that the Referee correctly dismissed claimant's hearing request because until the Department issues an order on reconsideration, jurisdiction remains with the Department. SAIF further argues that the Department's processing of claimant's reconsideration request complied with pertinent statutory mandates and time frames.

Our review is limited to the record developed at hearing. Because no hearing was convened and no evidence taken, we are unable to address the parties' contentions.

Neither party had an opportunity to clarify the procedural history of the Department's actions in the reconsideration process, nor to present evidence concerning the issue. For example, was the Department authorized to postpone reconsideration pending a medical arbiter's examination, if claimant did not request a medical arbiter? At the time it did so, was the Department authorized to further stay reconsideration proceedings to determine whether temporary rules would be required to rate claimant's impairment? Presentation of evidence concerning these procedural questions should aid in resolving the jurisdictional question, as well as the question of whether claimant is presently entitled to a hearing on the merits of her hearing request.

We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). 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, because there has been no record submitted for review, we conclude that the record is not sufficiently developed to address the parties' contentions and, therefore, a compelling basis for remand exists.[1]

Accordingly, we remand this matter to Referee Brazeau. The parties shall have the opportunity to clarify the issues for resolution, as well as present evidence regarding those issues. The Referee shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination and/or testimony. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated March 31, 1994 is reversed. Claimant's request for hearing is reinstated. This matter is remanded to Referee Brazeau for further proceedings consistent with this order.

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[1] We have faced a similar problem in recent cases. See e.g., Jack S. Koehler, 45 Van Natta 1728 (1993); Donald L. Grant, 45 Van Natta 1523 (1993). We recognize the worthy goal of expeditiously resolving disputes. However, when a motion to dismiss is contested, as here, it is frequently more expeditious to develop a record before granting the motion to dismiss, thereby eliminating the need to remand if a party requests Board review.

In the Matter of the Compensation of
THOMAS J. JUSTICE, Claimant
WCB Case No. 93-10344
ORDER ON REVIEW
Aaron & Baer, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

We adopt and affirm the Referee's order with the exception of his discussion of the opinion of Dr. Nathan, examining orthopedist, and with the following supplementation.

Claimant initially related numbness in his left hand and arm to lifting a garbage can while working on June 2, 1993. (Ex. 4). There is no evidence that claimant's condition was caused by a work injury. However, following further medical investigation and an undisputed diagnosis of bilateral CTS, claimant pursued the claim as an occupational disease claim. (Tr. 14).

On August 11, 1993, Dr. Nathan examined claimant, performed nerve conduction studies, and took a detailed description of claimant's work activities. (Ex. 7). Based on the results of the nerve conduction studies, Dr. Nathan opined that the major contributing cause of claimant's symptoms and need for treatment was an "intrinsic, neuropathic process." (Exs. 7-4, 14-1). Dr. Nathan also opined that there was no objective evidence that claimant injured his left median nerve in the June 2, 1993 lifting incident. (Exs. 7-4, -5). In addition, he stated that review of claimant's work activities gave "no evidence of biomechanical pressure at the respective anatomical tunnels of either median nerve, which is the location of [claimant's] neuropathies." (Ex. 7-4). Based on this analysis, in a December 27, 1993 report, Dr. Nathan opined that the work activities were not the major contributing cause of claimant's bilateral CTS. (Ex. 14-1).

Dr. Pennington, treating M.D., concurred with Dr. Nathan's August 1993 report; however, he also opined that, although it was uncertain whether claimant's lifting in early June contributed to his

symptoms, it was likely that the bilateral CTS developed over a longer period. (Ex. 8). Thus, Dr. Pennington's concurrence could be read as only a concurrence with Dr. Nathan's rejection of an injury theory. Nevertheless, Dr. Pennington's strongest causation opinion was that claimant's "repetitive picking up of trash cans" at his work as a trash collector was "a likely contributing cause of his condition." (Ex. 11). Although "magic words" are not necessary, Dr. Pennington's opinion does not rise to the level of proving that the work activities were the major contributing cause of the occupational disease. ORS 656.802(2).

We agree with the Referee's analysis of the opinion of Dr. Durkan, consulting orthopedist. Finally, we note that the only remaining medical opinion comes from Dr. Moser, consulting neurologist. However, Dr. Moser's opinion establishes only a possibility that the work "contributed" to the development of CTS, which is insufficient to meet claimant's burden of proof. ORS 656.802(2); Gormley v. SAIF, 52 Or App 1055 (1981).

ORDER

The Referee's order dated March 17, 1994 is affirmed.

In the Matter of the Compensation of
LINDA N. KIEF, Claimant
WCB Case No. 93-08770
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of that portion of Referee Michael V. Johnson's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 9, 1993, claimant, who was leaving the restaurant in which she was employed after completion of her shift, slipped and fell on ice in the employee parking lot enroute to her car. There were no witnesses. Claimant parked her car in the parking lot at the south end of the restaurant where all employees parked. Claimant was not required to park there, but her employers were aware that she did. The initials of employees' names were painted on parking spaces they customarily used. The space in which claimant parks had formerly been her mother's and was convenient to the back door of the restaurant. The employer and their managers did not testify at the hearing regarding the ownership and maintenance responsibilities concerning the parking lot. Claimant testified, however, that the managers would clean the parking lot and remove snow or ice. (Trs. 19, 20).

Claimant did not seek medical treatment until April 6, 1993, when she consulted Dr. Gilbert, who diagnosed an acute lumbar sprain. Dr. Gilbert later concluded that the slip and fall incident in January 1993 was the major contributing cause of claimant's need for medical treatment. (Ex 14-24). Although claimant was also examined by an orthopedic surgeon, Dr. Burr, he did not comment on the causation issue.

The Referee found that claimant's slip and fall occurred while claimant was in the course and scope of her employment, reasoning that the employer had sufficient control over the area of claimant's accident to bring claimant's injury within the "parking lot" exception to the "going and coming" rule. See Kowcun v. Bybee, 182 Or 271 (1947). The Referee also concluded that Dr. Gilbert's medical opinion established that the slip and fall was the "major contributing cause" of the condition for which claimant sought medical treatment. Accordingly, the Referee set aside the insurer's denial of claimant's injury claim.

In Rogers v. SAIF, 289 Or 633, 642 (1980), the Supreme Court adopted a unitary "work-connection" approach for assessing if the relationship between claimant's injury and employment is sufficient to render an injury compensable. Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the Court recently 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. Norpac Foods v. Gilmore, 318 Or 363 (1994). Both elements must be evaluated; neither is dispositive.

As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. SAIF v. Reel, 303 Or 210, 216 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). There are, however, exceptions to the general rule. One of those exceptions is the "parking lot rule."

In Norpac Foods v. Gilmore, supra, the Supreme Court addressed the "parking lot rule." The Court explained that application of this 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 her injury "arose out of" his employment. In other words, claimant must also establish a sufficient causal connection between her employment and the injury to prove compensability.

The insurer argues that the "parking lot rule" exception to the going and coming rule does not apply here because the record does not establish that the employer had the requisite control of the area of injury. 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). Year-round control is not even required. Montgomery Ward v. Malinen, supra, 71 Or App at 461.

Here, claimant testified that the managers of the restaurant maintained the parking lot where claimant was injured. Claimant's testimony was unrebutted by the employer. Moreover, the evidence indicates that the employer painted the names of employees on their customary parking spaces. This also evidences employer control over the area in which claimant was injured. Taken together, these factors lead us to conclude that the employer exercised sufficient control over the parking lot where claimant fell to bring this case within the "parking lot" rule. It therefore follows that claimant's injury occurred "in the course" of her employment. Norpac Foods, Inc. v. Gilmore, supra.

The insurer's citation to Denise C. Smith, 46 Van Natta 783 (1994) does not change the result. In Smith, the employer paid a nearby service station a rental fee for use of its parking spaces. The employer passed on the right to use the parking lot to its employees at no cost. We determined that the employer-granted right to use the parking lot evidenced sufficient control of the area in which the claimant was injured to be considered part of the employer's premises. Under these circumstances, we concluded that the "parking lot" exception to the "going and coming" rule was applicable, even though there there was no evidence that the employer ever maintained the service station lot or could require the service station to do so. 46 Van Natta at 783.

In this case, not only does the employer allow its employees to use the parking area in back of the restaurant, but there is also unrebutted evidence that the employer, through its managers, regularly maintained the parking area in which claimant was injured. Thus, we conclude that the facts of this claim even more strongly support a finding of employer control than those in Smith.[1]

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[1] Although a signatory to this order, Board Chair Neidig refers the reader to her special concurrence in Denise C. Smith, supra.

We now turn to the issue of whether claimant's injury "arose out of" her employment. Claimant was leaving the employer's premises immediately after work when she slipped and fell on ice while attempting to enter her car. Unlike the claimant in Gilmore, whose injury did not occur as a result of any hazard or condition associated with the employer's parking lot, claimant here sustained an injury directly caused by a hazard on the employer's premises. Because the employer maintained the area of injury and claimant's injury was caused by the accumulation of ice, there is a sufficient causal connection between her employment and the injury such that claimant's injury "arose out of" her employment. See Christopher C. Ciongoli, 46 Van Natta 1906 (1994) (The claimant's injury "arose out of" employment when brought about by conditions or hazards, including large pothole and gravel, associated with premises over which the employer had exercised control); Walter R. Adams, 46 Van Natta 1742, 1744 (1994) (where the claimant slipped and fell on snow covered sidewalk under his employer's control while on an unpaid lunch break, claimant's injury "arose out of" employment). Accordingly, we conclude that claimant has satisfied both prongs of the unitary "work-connection" approach delineated in Rogers v. SAIF, supra.

Finally, the insurer contends that, even if claimant's slip and fall occurred within the course and scope of her employment, she failed to prove medical causation. However, based on our review of Dr. Gilbert's unrebutted medical opinion that the January 1993 accident was the major contributing cause of claimant's medical treatment, we agree with the Referee that claimant has established medical causation. Thus, the Referee correctly set aside the insurer's denial.

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 May 11, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid directly to claimant's attorney by the insurer.

In the Matter of the Compensation of
JUDITH K. NIX, Claimant
WCB Case No. 93-02704
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Crumme's order that affirmed the January 22, 1993 Order on Reconsideration which did not award claimant additional unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's overall physical condition at the time of the most recent closure was essentially the same as it was at the time of the prior closure. Claimant was previously awarded 1 percent unscheduled permanent disability in 1991. (Ex. 28). Claimant argues that she is entitled to an additional award of unscheduled permanent disability on the basis that her January 1992 arthroscopic surgery resulted in a permanent change in her condition. We agree.

Before conducting a reevaluation of the extent of a claimant's permanent disability following closure of an aggravation claim, the claimant must establish a permanent worsening of her compensable condition since the last award or arrangement of compensation. See Stepp v. SAIF, 304 Or 375 (1987); former OAR 436-35-005(9) & OAR 436-35-007(5). 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 at the time of the Determination Order or Notice of Closure. Former OAR 436-35-003(2). Therefore, we apply the standards in WCD Admin. Order 6-1992, which were in effect at the time of the August 13, 1992 Determination Order.

Impairment Rating

At the time of claimant's June 5, 1991 Determination Order, Dr. Switlyk said that claimant should try to "avoid overhead use of her arm almost exclusively." (Ex. 22). After the January 1992 shoulder surgery and claim reopening, however, he reported:

> "I think she does have a permanent partial impairment of a mild degree. This is based on slight restriction in active range of motion, loss of ability to repetitively use her arm overhead, and for surgical excision of her acromion in the form of an acromioplasty." (Ex. 42).

In light of such circumstances, we find that claimant's compensable condition permanently worsened since the last award or arrangement of compensation. Consequently, she is entitled to a reevaluation of her permanent disability.

It is undisputed that Dr. Switlyk performed a surgical excision of claimant's acromion. (Ex. 42.) Therefore, claimant is entitled to 5 percent impairment for resection of the acromion. OAR 436-35-330(14).

Although we find that Dr. Switlyk's opinion establishes that claimant is unable to repetitively use her shoulder due to a chronic and permanent medical condition, former OAR 436-35-320(5)(a) provides that "[w]here the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment." Because we have decided claimant is entitled to a 5 percent award for resection of the acromion, she is not entitled to an additional award for a chronic condition.

We rely on Dr. Switlyk's June 1992 findings concerning claimant's range of motion. (Ex. 42). Although claimant's injured joint has less range of motion when compared to the contralateral joint, the contralateral joint motion exceeds the normals established under the rules. Under OAR 436-35-007(16), if the motion of the injured joint exceeds the values for ranges of motion established under these rules, the values established under these rules shall be used to establish impairment. None of the measurements found by Dr. Switlyk would allow an award for loss of range of motion in the shoulder. See OAR 436-35-330. Consequently, we conclude that claimant is not entitled to an award for loss of range of motion in her shoulder.

Social/Vocational Factors

As noted above, the appropriate standards for rating claimant's disability are in WCD Admin. Order 6-1992. Pursuant to former OAR 436-35-290(2), 436-35-300(2) and 436-35-310(2), for workers who have a physician's release to regular work, or who have returned to regular work at the time of the determination, the value for the age, education and adaptability factors is zero. "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer." Former OAR 436-35-270(3)(c). Accordingly, we first turn to a determination of whether claimant was released to, or returned to, regular work.

Here, claimant's at-injury job was assembly of steering wheels and overhead consoles. Dr. Switlyk approved her return to work in 1991 with the restriction that she almost entirely avoid overhead use of her left arm. (Ex. 22). Claimant returned to her regular work until her shoulder surgery in January 1992. (Tr. 19). After her surgery, claimant performed hood assembly. She testified that she had requested that assignment because it was not as heavy on her arms and didn't require the overhead lifting like her previous job. (Tr. 19). After her surgery, Dr. Switlyk reported that "[claimant] can continue working at her current job which is installing hoods. I think she can continue to work at her place of employment as long as it does not require anything but rare overhead use of her left arm." (Ex. 42).

Under these circumstances, we find that claimant did not return to her regular job of assembly of steering wheels and overhead consoles. See Jim M. Greene, 46 Van Natta 1527 (1994) (because claimant no longer performed the full range of his duties when he returned to work, he did not return to his regular work); George O. Hamlin, 46 Van Natta 492 (1994); Barbara J. Clanton, 45 Van Natta 291 (1993).

Having found that claimant was not released to, nor did she return to, her regular job, we turn now to a determination of the values for age, education and adaptability.

At hearing, the parties stipulated to the following: 1 for age and zero for formal education and training. (Tr. 7).

Skills

At hearing, claimant argued that the appropriate DOT code is 806.381-058, trailer assembler I. (Tr. 6 & 7). The employer does not dispute that category. This occupation is assigned an SVP of 3, entitling claimant to a value of 3. DOT 806.381-058; former OAR 436-35-300(4)(e).

Adaptability

Claimant's job of trailer assembler I is assigned a strength value of "medium" by the Selected Characteristics Defined in the Dictionary of Occupational Titles (SCODDOT). Here, claimant returned to her job, however, she is permanently restricted by her attending physician from performing overhead work. (Ex. 42). We conclude that claimant is unable to perform the full range of requirements of her medium strength job. Accordingly, we find that claimant's RFC is "medium/light" and she is entitled to an adaptability value of 2. 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 1 is added to her total education value of 3, the sum is 4. When that value is multiplied by claimant's adaptability value of 2, the product is 8. When that value is added to claimant's impairment value of 5, the result is 13 percent unscheduled permanent partial disability. Former OAR 436-35-280. Inasmuch as claimant previously received 1 percent unscheduled permanent disability as a result of her 1991 claim closure award, we find that she is entitled to an additional 12 percent unscheduled permanent disability award. See OAR 436-35-007(3)(a).

We adopt and affirm the Referee's order concerning the authorization for the employer to offset its $3,200 overpayment against the increased award. See Judith K. Nix, 45 Van Natta 2242 (1993).

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 one to 13 percent. Consequently, claimant's attorney is awarded 25 percent of this 12 percent increased compensation, not to exceed $3,800.

ORDER

The Referee's order dated December 9, 1993 is modified in part and affirmed in part. Claimant is awarded an additional 12 percent (38.40 degrees) unscheduled permanent disability for a total award of unscheduled permanent disability to date of 13 percent (41.60 degrees). Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. That portion of the Referee's order that authorized an offset is affirmed.

In the Matter of the Compensation of
JUDITH A. ROBINS, Claimant
WCB Case Nos. 92-01631, 92-00220, 91-13635 & 91-09956
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys
James Booth (Saif), Defense Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Michael V. Johnson's order which: (1) set aside the SAIF Corporation's responsibility denial, on behalf of Dalgety Foods, for claimant's current bilateral carpal tunnel condition; (2) upheld the compensability and responsibility denials of Liberty Northwest Insurance Corporation, on behalf of Agripac Inc., for the same condition; (3) upheld the compensability and responsibility denial of Fireman's Fund, on behalf of House of Fabrics, for the same condition; and (4) awarded claimant an assessed attorney fee in the amount of $3,000, payable proportionally by Liberty and Fireman's Fund. Fireman's Fund cross-requests review of that portion of the Referee's order which directed it to pay a share of the attorney fees assessed for claimant's counsel's services at hearing. On review, the issues are compensability, responsibility, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

When both compensability and responsibility are at issue, the threshold issue is compensability. Elizabeth Coomer, 41 Van Natta 2300, 2302 (1989). Here, both Liberty and Fireman's Fund denied compensability as well as responsibility, while SAIF denied only responsibility. Thus, compensability was contested at hearing. On review, Fireman's Fund contends that its compensability denial should be upheld, while claimant argues that all compensability denials should be set aside. Accordingly, we turn first to the compensability issue.

Compensability

The Referee concluded that claimant failed to prove the compensability of her current bilateral carpal tunnel condition as an occupational disease against either Liberty or Fireman's Fund, but he accepted SAIF's concession that claimant's current condition remains compensable against its insured. We agree with the Referee's determination that claimant's current carpal tunnel condition is compensable, but we do so based on the following reasoning.

First, we summarize the pertinent facts. Claimant has been employed seasonally at the same food canning facility for approximately 28 years. In 1979, claimant sustained an accepted bilateral carpal tunnel condition against SAIF's insured. Bilateral carpal tunnel release surgery was performed in 1979, and the claim closed with no permanent disability the same year. (Exs. 7, 9, 14).

In July 1990, claimant sustained a right shoulder and arm injury, which Liberty accepted by stipulation as right lateral epicondylitis and right shoulder impingement syndrome. (Ex. 22).

Claimant's seasonal work for Liberty's insured ended in November 1990. From November 1990 until August 1991, claimant was employed part-time as a retail sales clerk at House of Fabrics, a fabric retailer insured by Fireman's Fund.

In May 1991, claimant came under the care of Dr. Boyd, orthopedist. In the course of treating her right upper extremity conditions resulting from the 1990 work injury, he diagnosed recurrent bilateral carpal tunnel conditions.

In August 1991, claimant returned to her seasonal employment at Liberty's insured, but was released from work after working only two weeks due to carpal tunnel symptoms. Dr. Boyd performed bilateral carpal tunnel releases in September and November 1991.

On review, claimant concedes that her current bilateral carpal tunnel condition is appropriately analyzed as an occupational disease. Therefore, in order to establish the compensability of her current condition, claimant must show that work exposure was the major contributing cause of her disease or its worsening. ORS 656.802.

The evidence establishes that employment activities either caused or worsened claimant's carpal tunnel conditions. The medical evidence identifies the following contributory causal factors: (1) claimant's original, compensable carpal tunnel surgeries; (2) her compensable right elbow and shoulder injury; and (3) work activities subsequent to her 1979 carpal tunnel surgeries. No off-work activities or noncompensable conditions were identified as contributing to claimant's current carpal tunnel conditions. Accordingly, after our review of the record, we conclude that claimant's current bilateral carpal tunnel conditions are compensable.

Responsibility

Having determined that claimant's current condition is compensable, we turn to the responsibility issue.

In order for a carrier to shift responsibility to a subsequent carrier under ORS 656.308(1), it must show that the worker sustained a new compensable injury or occupational disease. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993). Proof of a new compensable occupational disease requires the carrier to establish that work conditions at the subsequent employment were the major contributing cause of an occupational disease. Id.

Claimant has an accepted 1979 bilateral carpal tunnel condition, for which SAIF is responsible. Claimant's current condition is also a bilateral carpal tunnel condition. Thus, in order to shift responsibility to a later carrier under ORS 656.308(1), SAIF has the burden to establish that claimant has sustained a new occupational disease caused by subsequent employment exposures. Therefore, in order to shift responsibility, SAIF must establish that subsequent work exposures are the major contributing cause of claimant's current bilateral carpal tunnel conditions, or of a pathological worsening of the accepted carpal tunnel conditions. ORS 656.308(1); 656.802.

After our review of the record, we agree with the Referee's evaluation of the medical opinions. We too find the opinion of Dr. Jewell more persuasive. Accordingly, relying on Dr. Jewell's opinion that the major contributing cause of claimant's current carpal tunnel conditions is scarring from her original, 1979 surgery, we conclude that SAIF has failed to carry its burden of proving that claimant has sustained a new occupational disease. Therefore, SAIF remains responsible for claimant's current bilateral carpal tunnel conditions.

Although the Referee found SAIF to be responsible for claimant's current condition, the order incorrectly states that SAIF's denial is approved. We correct the Referee's order to indicate that SAIF's denial is set aside.

Attorney Fees

The Referee awarded an assessed attorney fee for claimant's counsel's services at hearing regarding the compensability issue, payable one-third by Fireman's Fund and two-thirds by Liberty. Fireman's Fund cross-requests review on the attorney fee issue, contending that SAIF denied compensability as well as responsibility. According to Fireman's Fund, because SAIF is the responsible insurer, it bears the sole liability for attorney fees. We disagree.

In James McGougan, 46 Van Natta 1639 (1994), we considered whether a carrier's denial raised a compensability issue, or whether it simply denied responsibility. Noting that the carrier's denial specifically acknowledged compensability of the claim, advised that a paying agent would be requested, stated that only responsibility was being denied, and did not contain language reserving any compensability issues, we concluded that the carrier had only denied responsibility. Therefore, it was not responsible for payment of an assessed attorney fee.

We distinguished our holding in Linda K. Ennis, 46 Van Natta 1142, 1143 (1994), in which we concluded that a "Disclaimer of Responsibility and Claim Denial" raised an issue of compensability. In Ennis, the denial did not specifically address compensability. However, the document contained notice of hearing provisions, as well as statements that it was a denial of a claim for benefits and that a paying agent was not requested.

Here, SAIF issued a "Disclaimer of Responsibility" after both Liberty and Fireman's Fund had issued denials of responsibility and compensability. (Ex. 54; see also Exs. 38, 43A, 45, 47, 50). SAIF's letter stated its position that either Liberty or Fireman's Fund is responsible for the claim. The letter also advised that SAIF would not request appointment of a paying agent under ORS 656.307. The letter did not mention compensability, nor did it provide a notice regarding hearing rights as required in a denial of benefits. The letter provided only a notice advising claimant to make a claim against the other potentially responsible insurers. (Ex. 54).

Under these circumstances, we conclude that SAIF's "Disclaimer of Responsibility" did not raise an issue of compensability. In reaching this conclusion, we have particularly considered that SAIF's letter contains no indicia of a compensability denial, such as a reservation of compensability issues, language indicating that it is a denial of a claim for benefits, or a notice of hearing rights. Although SAIF advised it would not request a paying agent, we do not construe that statement alone as raising a compensability issue, particularly in light of the existence of two previous compensability denials by other potentially responsible carriers. Under such circumstances, no paying agent would be designated under ORS 656.307. Accordingly, we conclude that SAIF did not raise a compensability issue in its "Disclaimer of Responsibility." Therefore, it is not responsible for paying an assessed attorney fee. James McGougan, supra.

Because claimant's right to compensation was at risk due to the compensability denials of Liberty and Fireman's Fund, these two insurers created the need for claimant to establish the compensability of her claim. Therefore, the Referee correctly found both Liberty and Fireman's Fund responsible for the assessed attorney fee for services at the hearing level. See Safeway Stores, Inc. v. Hayes, 119 Or App 319, 323-24 (1993); Leland G. Townsend, 45 Van Natta 1074, 1075 (1993).

Because we have affirmed the Referee's order finding SAIF responsible, we accept claimant's concession that the attorney fee awarded by the Referee is adequate for her counsel's services at hearing.

Since claimant initiated Board review, no assessed attorney fee is available under ORS 656.382(2) regarding the compensability issue. Furthermore, 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 concerning the cross-appeal of Fireman's Fund. 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 November 29, 1993, is affirmed with the following correction. In lieu of that portion of the Referee's order which approved the SAIF Corporation's denial on behalf of Dalgety Foods, SAIF's disclaimer of responsibility is set aside. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DAVID J. SCHAFER, Claimant
WCB Case No. 94-01704
ORDER ON REVIEW
David C. Force, Claimant Attorney
Paul L. Roess, Defense Attorney

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Livesley's order which affirmed an Order on Reconsideration that awarded claimant 18 percent (27 degrees) scheduled permanent disability for loss of use or function of the right knee. On review, the issue is extent of scheduled permanent disability.

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

The employer contested a January 20, 1994 Order on Reconsideration which awarded claimant 18 percent scheduled permanent disability for his compensable right knee injury of December 5, 1991. The employer alleged that the medical evidence from claimant's attending physician, Dr. Singer, and the medical arbiter, Dr. Gritzka, did not establish that claimant's impairment was "due to" the compensable injury, as opposed to claimant's preexisting chondrocalcinosis and ulcerative colitis.

Dr. Singer, in his May 13, 1993 closing report, documented reduced range of motion in claimant's right knee. (Ex. 7). However, he did not specifically attribute it to claimant's compensable injury. Dr. Singer then commented: "He is medically stationary with very mild residual symptoms with pain with squatting and climbing stairs. It is likely that any residual problems that he has from this would be related to the inflammatory process and not to his work-related injury." (Ex. 7).

Dr. Gritzka also reported reduced range of motion, but did not specifically relate it to the compensable injury. Dr. Gritzka also concluded that claimant had limitations in his ability to repetitively use his right knee due to a chronic and permanent medical condition arising out of the accepted condition. (Ex. 9). Based on Dr. Gritzka's arbiter's examination, the reconsideration order awarded 18 percent scheduled permanent disability for decreased range of motion and a "chronic condition." (Ex. 10-3).

The Referee declined to reduce claimant's scheduled permanent disability award to zero as requested by the employer. The Referee interpreted Dr. Singer's closing report as indicating that only claimant's pain while climbing and squatting was related to the noncompensable inflammatory process. The Referee concluded that claimant's reduced range of motion was caused by the compensable injury in light of prior reports from Dr. Singer relating claimant's knee condition to the compensable injury. The Referee also concluded that Dr. Gritzka's impairment findings were due to the compensable injury, inasmuch as Dr. Gritzka did not ascribe claimant's reduced range-of-motion in his right knee to his noncompensable inflammatory diseases.

On review, the employer continues to assert that claimant has no permanent impairment attributable to the compensable right knee injury and that, therefore, claimant's scheduled permanent disability award should be reduced to zero. Based on our de novo review of the record, we agree with the Referee's interpretation of the medical evidence. Thus, we agree with the Referee that claimant's right knee impairment is due to the compensable injury.

Moreover, ORS 656.283(7) provides, in part:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

Because the employer is alleging that claimant's permanent impairment is not due to the compensable injury, it follows that the employer is contending that the "standards" were incorrectly applied in the

Order on Reconsideration. At hearing, the employer was the only party registering dissatisfaction with the reconsideration order. Since the employer was the dissatisfied party, it had the burden of establishing that the standards had been incorrectly applied, i.e., that the reconsideration order incorrectly related claimant's impairment to the compensable injury. See ORS 656.283(7); Roberto Rodriguez, 46 Van Natta 1722, 1724 (1994).

We have previously held that there is no requirement that a medical arbiter report only impairment findings that are "due to" the compensable injury. See Julie A. Widby, 46 Van Natta 1065 (1994). However, unlike Widby, where the medical arbiter commented on other noncompensable causes of the claimant's impairment, the arbiter in this case did not attribute claimant's impairment findings to noncompensable causes. In the absence of evidence that the arbiter rated impairment due to causes other than the compensable injury, we find that Dr. Gritzka's impairment findings are due to the compensable injury. Since the employer failed to satisfy its burden of establishing that the "standards" were incorrectly applied, the Referee did not err in affirming the reconsideration order. Roberto Rodriguez, supra. Alternatively, regardless of which party has the burden of proof, we would still find that claimant's impairment is due to the compensable injury.

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 $910, 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 counsel's statement of services and respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 22, 1994 is affirmed. For services on Board review, claimant's attorney is awarded $910, to be paid by the self-insured employer.

In the Matter of the Compensation of
TROY L. STAFFORD, Claimant
WCB Case Nos. 93-10007, 92-13105 & 93-06279
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Lundeen, et al., Defense Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Davison's Ready Mix, requests review of Referee Brown's order that: (1) declined to grant its motion to dismiss claimant's request for hearing concerning Liberty's denial of claimant's right carpal tunnel syndrome claim; (2) set aside its denial of responsibility for claimant's right carpal tunnel syndrome; (3) upheld the denials of responsibility of the SAIF Corporation, issued on behalf of Medford Corporation, and Medco, a self-insured employer, for the same condition; and (4) assessed a penalty and related attorney fee against Liberty for an allegedly unreasonable denial. On review, the issues are motion to dismiss, responsibility, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

At hearing, Liberty sought to dismiss claimant's request for hearing against it on the basis that claimant did not comply with the filing requirements in ORS 656.308(2). The Referee denied the motion on the basis that claimant timely filed his claim under ORS 656.807(1).

Liberty argues that, because claimant did not file his occupational disease claim for right carpal tunnel syndrome within 60 days of Medco's disclaimer of responsibility naming Liberty as responsible for claimant's condition, claimant's request for hearing from Liberty's denial should be dismissed.

ORS 656.308(2) provides that a carrier which intends to disclaim responsibility "shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim." The worker then has 60 days from the date of mailing of the notice to file a claim with the other employer or insurer.

In Jon F. Wilson, 45 Van Natta 2362 (1993), 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. 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.

Liberty contends that Wilson is distinguishable because that case involved an incorrect disclaimer and in the present case, Medco properly complied with ORS 656.308(2). We rejected a similar argument in Marilyn K. McMasters, 46 Van Natta 800 (1994). In that case, we said:

> "Although the present case does not involve the 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."

ORS 656.308(2) provides that any "employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided" in the statute. (Emphasis added). Here, both Medco and SAIF issued disclaimers of responsibility, naming Liberty as a responsible party. (Exs. 15, 28). At hearing, both parties also disputed that they were responsible for claimant's condition.

In Jon R. Wilson, supra, we noted that we were unable to detect an intent in the legislative history of ORS 656.308 to supplant or otherwise alter the one-year claim filing period set out in ORS 656.807. 45 Van Natta at 2363 n. 1. An occupational disease claim is considered "void" unless filed within one year of when the worker first discovers or becomes disabled from the disease. ORS 656.807(1). Claimant complied with the filing requirements of ORS 656.807(1).

Therefore, we apply the reasoning of Marilyn K. McMasters, supra, to this case. We conclude that claimant's failure to comply with the 60 day time limit of ORS 656.308(2) does not bar him from proving the compensability of his claim. Consequently, we concur with the Referee's decision to deny Liberty's motion to dismiss claimant's hearing request from Liberty's denial. We proceed to consider responsibility for claimant's right carpal tunnel syndrome.

Responsibility

Claimant worked for Medco until December 1990. In May 1987, SAIF, Medco's carrier at that time, accepted a claim for right shoulder and wrist tendonitis. In June 1990, when Medco was self-insured, Medco accepted a claim for bilateral wrist strain. In September 1991, claimant began working for Liberty's insured, Davison's Ready Mix.

The Referee found that claimant's work activities at Davison's were the major contributing cause of a worsening of his right carpal tunnel syndrome and, apparently based on ORS 656.308(1), concluded that Liberty was responsible for the claim. Liberty, Medco, and SAIF all assert that, because right carpal tunnel syndrome was not previously accepted, responsibility should be determined pursuant to the last injurious exposure rule rather than ORS 656.308(1).

ORS 656.308(1) is applicable when the medical treatment or disability for which benefits are sought involves a condition that previously has been processed as a part of a compensable claim. Smurfit Newsprint v. DeRosset, 118 Or App 368, 371 (1993). Here, claimant has accepted claims with SAIF for right shoulder and wrist tendonitis and with Medco for bilateral wrist strain. (Exs. 4, 11). Although claimant was first diagnosed and sought treatment for right carpal tunnel syndrome in 1987, the medical evidence shows that the tendonitis and strain were separate conditions from the carpal tunnel syndrome. (Exs. 2-2, 3, 10-5, 10-1). There is no evidence that the carpal tunnel syndrome was accepted or processed with the tendonitis and strain claims. Therefore, we conclude that the carpal tunnel syndrome is not the "same condition" as the compensable tendonitis and strain injuries and that ORS 656.308(1) is not applicable. See Smurfit Newsprint v. DeRosset, supra. Furthermore, based on evidence that claimant's work at each employer could contribute to his condition, we apply the last injurious exposure rule. (Exs. 22, 31). Bracke v. Baza'r, 293 Or 239 (1982).

Under the last injurious exposure rule, the potentially causal employer at the time of disability is assigned initial liability for the disease. Bracke v. Baza'r, supra. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396 (1993).

In March 1987, claimant first sought treatment for, and was diagnosed with, right carpal tunnel syndrome. (Exs. 2-2, 3). Inasmuch as SAIF was on the risk on that date, it is assigned initial liability for the claim. See Bracke v. Baza'r, supra; Timm v. Maley, supra. However, SAIF may shift responsibility to a subsequent carrier if it shows that claimant's work with that carrier's insured worsened his underlying condition, and not just his symptoms. Bracke v. Baza'r, supra, 293 Or at 250; Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795, 799, rev den 300 Or 162 (1985).

The record contains two opinions regarding this issue. Dr. Kho, neurologist, examined claimant on behalf of Medco in June 1990 and December 1992. Based on the latter examination, Dr. Kho found that the work at Davison's Ready Mix "independently contributed to the development/worsening/aggravation" of claimant's carpal tunnel syndrome. (Ex. 21-4). Dr. Kho based his opinion on claimant's history that claimant was "minimally symptomatic" until beginning work at Davison's, which required hand intensive labor, and the increase in "laboratory values" between a June 1990 study and December 1992 study. (Id).

Dr. Reimer, neurologist, and Dr. Fuller, orthopedic surgeon, examined claimant at Liberty's request in November 1993. The panel was "unable to identify any evidence of worsening of the underlying pathology" and found that the "major contributing cause of [claimant's] carpal tunnel syndrome clearly is the work he was engaged in between 1983 and 1990" since claimant was diagnosed with carpal tunnel syndrome during this period. (Ex. 31-4). The panel also found the "very minor difference" in the studies did not indicate an underlying change in pathology. (Id. at 5).

When there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Under this standard, we find Dr. Kho's opinion to be more persuasive. First, we are persuaded that Dr. Reimer and Dr. Fuller based their opinion on a history that claimant's symptoms simply continued unabated after onset in 1987. The "history" portion of their report stated that claimant's hand "continued to bother him" after he began working for Davison's and that claimant's "symptomatology simply continued" with such work. (Ex. 31-2, 31-5). As shown by the medical reports and claimant's testimony, claimant's right hand symptoms decreased before he began working at Davison's, after which time symptoms returned to their original level. (Exs. 17-1, 21-2, Tr. 19).

Thus, we find that Dr. Reimer and Dr. Fuller based their opinion on an inaccurate history. Furthermore, Dr. Kho examined claimant before and after claimant began working at Davison's and resulting increased symptoms, and, therefore, was more familiar with claimant's condition.

Based on Dr. Kho's report, we find that claimant's underlying condition was worsened by his work at Davison's. Therefore, we conclude that responsibility for claimant's right carpal tunnel syndrome shifts from SAIF to Liberty. See Bracke v. Baza'r, supra; Fred Meyer v. Benjamin Franklin Savings & Loan, supra.

Penalties and Attorney Fees

On review, Liberty's challenge to the Referee's assessment of a penalty is contingent on finding that the Referee erred in not granting its motion to dismiss claimant's request for hearing or finding that it is not responsible for claimant's right carpal tunnel syndrome. Inasmuch as we have affirmed the Referee on both issues, we adopt and affirm the Referee's penalty award. See ORS 656.262(10).

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $1,500, payable by Liberty. 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 December 29, 1993 as amended December 30, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, payable by Liberty.

In the Matter of the Compensation of
ROGER L. WOLFF, Claimant
WCB Case No. 93-06586
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Hoguet's order that set aside its denial of claimant's current left knee condition and claim for treatment, including surgery. In its brief, SAIF argues that the Referee lacked jurisdiction to address arguments regarding the compensability of claimant's current condition as a consequence of his December 1980 injury. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

SAIF argues that, because claimant neither filed a claim for a left knee injury resulting from his December 1980 work accident, nor requested a hearing regarding the alleged December 1980 knee injury, the Referee lacked jurisdiction to "entertain any arguments concerning [the] compensability of claimant's current [left knee] condition as a consequence of the December 1980 injury." (SAIF's Appellant's Brief at 7). We disagree.

The present case arose from SAIF's denial of claimant's 1993 claim for his current left knee condition. (See Ex. 30). Claimant timely requested a hearing regarding that denial. Accordingly, we conclude that, although the claimant's alleged failure to file a claim or request a hearing for a left knee injury as a result of the December 1980 accident may affect the analysis of this matter, because claimant timely requested a hearing regarding SAIF's 1993 denial, the Referee had jurisdiction to determine whether claimant's current left knee condition was compensably related to his December 1980 injury. See ORS 656.283.

Compensability

The Referee concluded that claimant established the compensability of his current left knee condition and need for treatment as a resultant condition under ORS 656.005(7)(a)(B). Claimant argues that, by accepting his November 1980 left knee contusion, by paying for claimant's left knee surgeries, and/or by virtue of the October 1981 Determination Order that listed "osteochondritis" as one of claimant's diagnoses (Ex. 13-2), SAIF accepted his preexisting osteochondritis dessicans. We conclude that, by virtue of its failure to object to the October 1981 Determination Order "osteochondritis" award, SAIF is barred by claim preclusion from denying that claimant's osteochondritis dessicans is part of claimant's November 1980 compensable claim.

In November 1980, claimant injured his left knee at work. X-rays revealed a bone chip and osteochondritis dessicans with a sclerotic border. (Ex. 2). SAIF accepted a left knee contusion, but not the osteochondritis dessicans. (Ex. 4).

Claimant also sustained a work-related back injury on December 20, 1980. Additionally, he fell at work on December 25, 1980. He filed an "801" form for a back injury, but not left knee injury, related to the December 25 accident. (Ex. 4A). SAIF never formally accepted or denied a December 1980 left knee injury claim.

Subsequently, in April 1981, claimant saw his treating physician, Dr. Thomas, for complaints of left knee pain. (Ex. 5). Claimant related his onset of left knee symptoms to the December 1980 fall. (Id.) Dr. Thomas concluded that claimant had a loose bony fragment that likely was the result of an osteochondritis dessicans defect in the medial femoral condyle. (Exs. 6, 7). In May 1981, Thomas removed a loose cartilegenous body from claimant's left knee. (Exs. 9, 10). SAIF paid claimant compensation, including medical expenses, related to his left knee condition.

Claimant's November 1980 left knee claim was closed by an October 1981 Determination Order that awarded him 10 percent permanent disability. (Ex. 13). The closing examination revealed that claimant's osteochondritis dessicans most likely was preexisting, and that a bone fragment had become loose as a result of the November 1980 knee injury. (Ex. 12-2). The Determination Order specifically listed "osteochondritis" as one of claimant's conditions. (Id. at 2). SAIF paid claimant benefits pursuant to, and did not appeal, the Determination Order.

In January 1986, claimant's November 1980 knee claim was reopened for additional surgery. (Ex. 18). An October 1986 Determination Order closed the claim without an award of additional permanent disability. (Ex. 24). In June 1987, the parties entered into a stipulation regarding the November 1980 left knee claim. The stipulation awarded claimant additional permanent disability for his left knee condition. (Ex. 25-1, -2). Neither the October 1986 Determination Order nor the ensuing stipulation mentioned claimant's osteochondritis dessicans. SAIF did not appeal either the October 1986 Determination Order or the stipulation.

In 1993, claimant again experienced left knee pain. (Ex. 27). This dispute arose when SAIF denied Dr. Thomas' request for authorization to perform another surgery on claimant's left knee. (See Ex. 30). The medical experts agree that claimant's underlying osteochondritis dessicans preexisted his November 1980 knee injury. (Exs. 15-2, 32-2; see Ex. 33).

SAIF argues that, because claimant's osteochondritis dessicans preexisted his 1980 work exposure, the case must be analyzed under ORS 656.005(7)(a)(B). We need not address that issue, because we conclude that this matter is controlled by Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994).

In Messmer, the insurer accepted a claim that had been diagnosed as thoraco-cervical strain and myofascitis. After the claimant's physician diagnosed cervical degenerative disc disease, the insurer neither accepted nor denied the condition; it did, however, authorize surgery for it. A Determination Order thereafter awarded permanent partial disability based in part on the effects of the surgery for the degenerative disc disease. After the claimant's neck pain subsequently worsened, the claimant's physician requested authorization to perform additional cervical surgery. The employer denied the compensability of the cervical condition. The claimant appealed, arguing, inter alia, that the employer's failure to seek review of the Determination Order barred it from then denying the compensability of the worsening of the degenerative condition.

We concluded that the employer was not precluded from denying the compensability of claimant's aggravation claim, on the ground that neither the employer's approval of surgery nor its failure to challenge the Determination Order constituted an acceptance of the claimant's degenerative neck condition. Richard J. Messmer, 45 Van Natta 874 (1993). The Court of Appeals disagreed with us. Citing Hammon State Line v. Stinson, 123 Or App 418 (1993), the court stated that an award made by a Determination Order is based on certain underlying facts, one of which is the scope of the compensable claim. Therefore, it reasoned, claim preclusion bars a carrier from later arguing that the condition for which an award was made is not part of the compensable claim. 130 Or App at 258.

Applying that analysis to the facts, the Messmer court concluded that, although the employer's payment of compensation did not, by itself, constitute an acceptance of claimant's cervical degenerative condition, ORS 656.262(9), its failure to challenge the award on the ground that it included an award for a noncompensable condition precluded it from denying that the cervical degenerative condition was part of the compensable claim. Id. The court concluded that the result was not that the employer had accepted the degenerative condition; rather, it was that the employer was barred by claim preclusion from denying that that condition was part of the claimant's compensable claim. Id.

We reach the same conclusion in this case. The condition at issue is claimant's left knee osteochondritis dessicans. Although SAIF never formally accepted that condition, it did pay claimant compensation for that condition. Furthermore, SAIF did not challenge the October 1981 Determination Order that specifically listed "osteochondritis" as one of claimant's conditions. SAIF's payment of compensation did not, by itself, constitute an acceptance of claimant's cervical degenerative condition. ORS 656.262(9). Nevertheless, in light of Messmer, we conclude that SAIF's failure to challenge the October 1981 award on the ground that it included an award for a noncompensable condition precludes it from denying that the osteochondritis dessicans was part of the November 1980 compensable claim.

The result is not that SAIF has accepted claimant's osteochondritis dessicans; rather, it is that SAIF is barred by claim preclusion from denying that it is part of claimant's November 1980 claim. Messmer, supra, 130 Or App at 258. That the October 1986 Determination Order and subsequent stipulation did not mention osteochondritis dessicans does not alter our conclusion because, by the time those documents issued, the 1981 Determination Order had long been final; furthermore, SAIF did not appeal either of those decisions. Accordingly, we affirm the Referee's decision setting aside SAIF's denial of claimant's current left knee condition and claim for treatment.

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 is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have considered the time devoted to this case (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 January 13, 1994 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JOB G. LOPEZ, Claimant
WCB Case No. 93-08872
INTERIM ORDER
Emmons, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Claimant has requested review of that portion of Referee Nichols' order that affirmed the Director's order upholding the managed care organization's (MCO's) disapproval of her attending physician's request for authorization of back fusion surgery. In its brief, the SAIF Corporation contends that the Referee erred in denying its motion to dismiss claimant's hearing request for lack of jurisdiction.

One of the potential issues subject to our review is whether medical treatment arising from an MCO constitutes a "matter concerning a claim" over which the Hearings Division has jurisdiction, see ORS 656.283(1), 656.704(3), or whether the dispute is solely subject to the resolution procedures set forth by the MCO and the Director under ORS 656.260. While proceeding with our review, we determined that this is a question of first impression that could have a significant impact on the workers' compensation system.

Consequently, on September 30, 1994, we notified the participants that we had concluded that the case had satisfied the criteria for granting oral argument. See Jeffrey B. Trevitts, 46 Van Natta 1767 (1994); Ruben G. Rothe, 45 Van Natta 369 (1993). On October 3, 1994, we invited the Workers' Compensation Division of the Department of Consumer and Business Services (Department) to submit an amicus curiae brief addressing the above-mentioned jurisdictional issue. On October 17, 1994, we scheduled oral argument for Thursday, December 15, 1994 at 9:30 a.m.

On October 18, 1994, the Department, by and through the Department of Justice, filed a motion to intervene in this matter. The Department asserts that, in view of its authority to administer, regulate and enforce the statutory scheme governing MCOs, and the fact that this case arises from a challenge to a Director's order under ORS 656.260, we should grant its motion to intervene. After fully considering this matter, we deny the Department's motion.

The Department refers us to Trojan Concrete v. Tallant, 107 Or App 429, rev den 312 Or 151 (1991) in support of its motion. In Tallant, a claimant and a noncomplying employer entered into a disputed claim settlement (DCS) resolving the employer's hearing request from the SAIF Corporation's acceptance of the claim. Both SAIF and the Department elected not to appear at the hearing. No hearing was convened; rather, the claimant and the employer entered into the DCS, to which neither SAIF nor the Department[1] was a party. A referee approved the DCS. SAIF and the Department requested review of the agreement. The employer moved to dismiss the request for review on the ground that neither SAIF nor the Department had standing to request review of the agreement. The Court of Appeals rejected that argument. The court concluded that, in view of the Department's responsibility to reimburse SAIF for any expenditures on behalf of the NCE, the Department had a pecuniary interest in the matter sufficient to afford it standing to seek Board review of the agreement. 107 Or App at 433.

Here, the Department does not contend that it has any pecuniary interest in this matter; indeed, we have found none. Moreover, the issue in Tallant was the Department's standing to seek Board review of a DCS. Here, in contrast, the issue concerns the Department's entitlement to intervene in an ongoing matter involving a claimant's medical services dispute with an MCO. For those reasons, we find Tallant distinguishable from the instant case.

The Department also relies on Kelsey v. Drushella-Klohk, 128 Or App 53 (1994). In that case, the Department[2] issued an order finding that the employer was a noncomplying employer. SAIF

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[1] In Tallant, the "Department" referred to the Department of Insurance and Finance (or "DIF"), as the Department of Consumer and Business Services was formerly named.

[2] The Kelsey court referred to the Department as "DIF", as it was then called. See supra, note 1.

accepted the claim, after which the employer requested a hearing. The Department took an active role at hearing, to defend its order of noncompliance. A referee set aside the Department's order of noncompliance as well as SAIF's acceptance of the claim. The referee mailed a copy of the final order to the Department.

The claimant requested Board review, but did not serve the Department, or anyone on the Department's behalf, with the request for review. The Department moved to dismiss the appeal, which the Board denied. The Board relied on ORS 656.005(20), which defines "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." It reasoned that, because the Department did not fall under ORS 656.005(20)'s definition of "party," the Department need not be served with notice of the claimant's request for review.

The Kelsey court disagreed, noting that, under ORS 656.003, the definition of "party" contained in ORS 656.005(20) does not apply "where the context requires otherwise." The court held that, "when the Board's adjudication is to review an order of [the Department] regarding noncompliance, context requires otherwise, and [the Department] must be treated as a party entitled to be served with notice [of a request for review] under ORS 656.295(2)." 128 Or App at 58.

Kelsey is inapposite. There, unlike the present case, the Department actively participated at the hearing regarding its noncompliance order. In other words, the Department "intervened" at the hearing level, while the record was being developed and the issues litigated. Here, in contrast, the Department played no role at the hearing; indeed, it was only after we invited it to submit an amicus brief that the Department demonstrated any interest in this matter. Furthermore, the issue in Kelsey was whether, in the NCE context, the Department was a "party" entitled to be served with a claimant's request for Board review. Here, the Department is requesting leave to intervene at the Board level in a case previously developed and litigated at the hearing level. Accordingly, for these reasons, we find Kelsey distinguishable from the case at bar.

Finally, the Department argues that, in light of the Director's authority to administer, regulate and enforce ORS 656.260, the statute governing MCOs, it has a compelling interest in participating fully in this proceeding. We disagree.

In Richard A. Colclasure, 46 Van Natta 1246 (order on remand), 46 Van Natta 1667 (1994) (second order on remand), we granted the Department's motion to intervene. In Colclasure, we were conducting our review on remand of a Director's vocational assistance order in accordance with the Supreme Court's decision in Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993). In light of the Department's regulatory responsibilities and its pecuniary interest (the Department is responsible for the payment of vocational assistance costs in claims arising before 1986), and the fact that the claimant's compensable injury arose in 1982, we held that the Department had standing to intervene on remand. 46 Van Natta 1248.

Here, the Department unquestionably has a significant interest concerning the application of ORS 656.260 and its regulatory and administrative responsibilities under that statute. Nevertheless, its interest is not pecuniary in that it is not entrusted with the responsibility for providing reimbursement for carriers' claim costs as was the case in Tallant, Kelsey and Colclasure. See Al S. Davis, 44 Van Natta 931 (1992) (Department's motion to be joined during Board review of a referee's order concerning the Director's order under ORS 656.327(2) denied because the Department did not have a stake in the outcome of the matter, but rather had a general interest in the interpretation of the statute).

For these reasons, we deny the Department's motion to intervene. Considering the Department's role in administering and regulating MCOs, we recognize that it has a general interest in this dispute. Therefore, we will continue to consider any written argument submitted on the Department's behalf as an amicus curiae brief. However, consistent with the briefing schedule established by our October 3, 1994 letter to the Department, as modified by our October 17, 1994 letter to the parties (which was copied to the Department), any amicus curiae briefs must be filed on or before November 18, 1994.[3]

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[3] In our October 3, 1994 letter to the Department, we inadvertently set a December 18, 1994 deadline for the filing of any amicus briefs. Subsequently, in a letter to the parties' attorneys, which was copied to the Department and the Board's Hearings Division, we clarified that the filing deadline for amicus briefs in this matter was November 18, 1994.

Accordingly, oral argument has been scheduled for Thursday, December 15, 1994 at 9:30 a.m. in a hearing room at the Board's Salem office. At that time, claimant and the SAIF Corporation shall present their oral arguments concerning the issue we have previously identified for consideration. Once oral arguments are concluded, we will continue 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.

November 2, 1994 Cite as 46 Van Natta 2307 (1994)

In the Matter of the Compensation of
VERDA K. HARMON, Claimant
WCB Case No. 92-11747
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) excluded "post-reconsideration" medical reports addressing claimant's medically stationary status; (2) found that claimant's condition was medically stationary April 16, 1992; and (3) awarded claimant 20 percent (64 degrees) unscheduled permanent disability for a cervical and right shoulder condition. On review, the issues are evidence, medically stationary/offset and extent of unscheduled permanent partial disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for the finding that claimant was medically stationary on April 16, 1992. We instead conclude that claimant was medically stationary as of May 18, 1991.

We make the following additional findings of fact and ultimate fact.

On September 10, 1992, claimant filed a timely hearing request challenging the permanent disability compensation awarded by the June 4, 1992 Notice of Closure and the September 2, 1992 Order on Reconsideration. On November 25, 1992, SAIF filed a timely cross-request for hearing from the Notice of Closure and Order on Reconsideration.

The lost cervical and right shoulder ranges of motion noted by Dr. Martens are materially related to claimant's compensable motor vehicle accident.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

We adopt and affirm the Referee's permanent disability award.

Evidence and Offset

The Referee found that claimant was medically stationary as of April 16, 1992. Accordingly, the Referee authorized an offset for temporary disability benefits paid after that date. In finding that claimant was stationary on April 16, 1992, the Referee excluded certain "post-reconsideration" medical reports identified as Ex. 77, 78, 79 and 80. These excluded reports establish that claimant was medically stationary on May 18, 1991. The Referee excluded the reports because they were generated after the September 2, 1992 Order on Reconsideration.

On review, SAIF contends that the Referee improperly excluded these reports. SAIF asks the Board to admit the reports into the record, find claimant medically stationary as of May 18, 1991, and authorize an offset for temporary disability compensation paid after that date.

After the Referee issued his order, the Board addressed this issue in Andrea M. Gildea, 45 Van Natta 2293 (1993). In Gildea, the Board concluded that the limitations on "post-reconsideration" evidence provided in ORS 656.268(5) and OAR 436-30-050(4)(f) are not applicable to a Referee's determination of a claimant's medically stationary status. In light of the Board's ruling in Gildea, claimant concedes that the reports at issue here should not have been excluded because they were generated after the reconsideration process.

Nevertheless, claimant argues that the reports were properly excluded because the Referee did not have jurisdiction over the medically stationary/offset issue for which the reports were offered. Specifically, claimant contends that SAIF failed to timely request a hearing challenging the April 16, 1992 medically stationary date identified in the Notice of Closure.

We are not persuaded by claimant's argument. The medically stationary date/offset issue was properly before the Board as a result of SAIF's November 25, 1992 cross-request for hearing from the Notice of Closure and Order on Reconsideration. Moreover, assuming no timely cross-request had been filed, these issues were properly before the Referee as a result of claimant's timely request for hearing from the June 4, 1992 Notice of Closure and the September 9, 1991 Order on Reconsideration. Judith L. Duncan, 45 Van Natta 1457 (1993). Thus, SAIF would not be barred from raising these issues even if it had not filed a timely cross-request for hearing.

Accordingly, we conclude that the Referee improperly excluded Exhibits 77, 78, 79 and 80. Inasmuch as these exhibits are admissible and included in the file, we consider them in conducting our review.

Claimant's attending physician, Dr. Oltman, gave conflicting opinions concerning when claimant became medically stationary. However, based on a preponderance of the medical evidence, including Exhibits 77 through 80, we conclude that claimant's condition was medically stationary on May 18, 1991. Because we have found claimant medically stationary on May 18, 1991, we authorize the requested offset for temporary disability compensation paid after that date.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for reduction of claimant's permanent disability 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 fee for claimant's attorney's services on review concerning the permanent disability issue is $500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 7, 1993, as reconsidered October 18, 1993, is affirmed in part and reversed in part. The SAIF Corporation is authorized to offset temporary disability compensation paid after May 18, 1991 against claimant's present and future awards of permanent disability compensation in this claim. The Referee's evidentiary ruling is reversed. The remainder of the Referee's order is affirmed. SAIF shall pay claimant a $500 assessed fee for services on review regarding the permanent disability issue.

In the Matter of the Compensation of
DANIEL L. KIBBEE, Claimant
WCB Case No. 93-07623
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Nichols' order that upheld the insurer's denials of claimant's claim for L5-S1 spondylolisthesis. On review, the issue is compensability.

We adopt and affirm the Referee's order, with the exception of the last sentence of the findings of fact, and with the following supplementation.

Claimant essentially argues that his May 1993 compensable lumbosacral strain combined with his preexisting L5-S1 spondylolisthesis to form a "resultant" disability. Specifically, he argues that his preexisting spondylolisthesis was aggravated as a result of the lumbosacral strain.

To prevail on a "resultant" condition theory under ORS 656.005(7)(a)(B), claimant must establish that his compensable injury is and remains the major contributing cause of his resultant disability. ORS 656.005(7)(a)(B) applies only if a preexisting condition combines with a compensable injury.

Here, it is questionable whether the medical evidence establishes that claimant's compensable low back strain "combined with" his preexisting L5-S1 spondylolisthesis. Dr. Weinman, one of claimant's treating physicians, initially diagnosed lumbosacral strain aggravating preexisting L5-S1 Grade I spondylolisthesis. (Ex. 6-2; see also Ex. 14-9, -10). However, Dr. Weinman also stated that it was highly unlikely that claimant's spondylolisthesis had been structurally altered by the injury. (See Exs. 12a, 14-8). Furthermore, Dr. Weinman concluded that some of claimant's symptoms (i.e., shooting leg pain) may not have been related to his work injury. (Ex. 14-16, -17). In light of that evidence, we cannot conclude that this claim triggers the "combination" requirement of ORS 656.005(7)(a)(B).

Assuming arguendo that claimant had established a combination of his compensable injury and preexisting condition, we nevertheless conclude that claimant has failed to establish the compensability of his spondylolisthesis under ORS 656.005(7)(a)(B). In reaching that decision, we particularly rely on Dr. Weinman's statement that some of claimant's symptoms may not have been related to his work injury (Ex. 14-16, -17), and the fact that no other medical evidence addresses whether claimant's compensable injury is and remains the major contributing cause of his "resultant" disability.

Furthermore, we reject claimant's argument that his preexisting spondylolisthesis was aggravated as a result of his lumbosacral strain. In deposition, Dr. Weinman testified that claimant's bony structures and spondylolisthesis had not changed (i.e., had not worsened); rather, he explained, what may have happened is that "a loose piece of bone kind of bounce[d] around on the dural sack," causing swelling. (Ex. 14-9, -10). In other words, claimant's bony structure may have pinched the dural sac, but the spondylolisthesis itself did not change. (Id).[1] We find that evidence insufficient to establish an "aggravation" of claimant's spondylolisthesis.

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[1] In his brief, claimant argues, "Symptomatic worsening of a preexisting condition is compensable if it requires medical services or results in disability. There is no need to show that the worsening is permanent. See Weller v. Union Carbide, 288 Or 27 (1979)[.]" That argument improperly mixes two separate concepts. The first sentence is an accurate statement of the holding in U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), which concerned the compensability, under ORS 656.005(7)(a)(B), of a preexisting condition rendered symptomatic by a compensable injury. Compensability of such a claim is determined on whether, after assessing the relative contribution of different causes, the work incident is the major contributing cause of the disability or need for treatment of the resultant condition. See Dietz v. Ramuda, 130 Or App 397 (1994). The second sentence of claimant's argument, as demonstrated by its reliance on Weller, concerns a worsening in the occupational disease context. Moreover, while it is true that a "temporary" pathological worsening may be compensable as an occupational disease; Weller, supra, 288 Or at 36-37, claimant's argument fails to note that, for a preexisting condition to be compensable under ORS 656.802(2), there must be a pathological, and not merely a symptomatic, worsening of the preexisting condition. Id. at 35.

For these reasons, we agree with the Referee that claimant has failed to establish the compensability of his L5-S1 spondylolisthesis. Accordingly, we affirm the Referee's decision upholding the insurer's denial of that condition.

ORDER

The Referee's order dated February 8, 1994 is affirmed.

November 3, 1994 Cite as 46 Van Natta 2310 (1994)

In the Matter of the Compensation of
GARY A. BORD, Claimant
WCB Case No. 94-01343
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Herman's order that awarded claimant's counsel an assessed attorney fee for prevailing over its de facto denial of claimant's herniated disc condition. On review, the issue is attorney fees.

We adopt and affirm the Referee's order.[1]

Claimant's attorney submitted a statement of services for an attorney fee on review. Inasmuch as the issue on review solely concerns attorney fees, there is no entitlement to an attorney fee award for services on review. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated May 3, 1994 is affirmed.

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[1] On review, claimant objects to the insurer's introduction of new evidence in Footnotes 1 and 2 on page 4 of its brief. Footnote 1 contains a quotation from The Oregonian regarding the interpretation of MRIs and Footnote 2 contains two quotations from the New England Journal of Medicine regarding the same matter. The insurer claims that the material contained in the footnotes is not evidence, but a form of argument, in that the footnotes reiterate matters the Board is "presumed to already know." (App.'s Reply Brief at 3).

The insurer argues that an MRI cannot be a "claim" under workers' compensation law until it is interpreted by a physician. To the extent that the insurer offers the quoted material in the footnotes as evidence supporting its argument, it is not a part of the record and we do not consider it. ORS 656.295(5); Groshong v. Montgomery Ward, 73 Or App 403 (1985) (Review by the Board is statutorily limited to evidence found in the record from the hearing below). Moreover, it is not the type of evidence we take judicial notice of, and, to that extent, we do not consider it. Groshong, supra.

In the Matter of the Compensation of
LUCILLE BOYER, Claimant
WCB Case No. 93-09848
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Black's order that upheld the insurer's denial of claimant's occupational disease claim for bilateral shoulder and neck fibrositis and bilateral carpal tunnel conditions. Claimant seeks remand for the admission of a "post-hearing" medical report from her attending physician. On review, the issues are remand and compensability. We deny the motion for remand and affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions. On page 3 of the Opinion and Order, we make the following changes. In the second full paragraph, the reference to Dr. Herring's examination of January 1993 should be February 1993. (Ex. 8). In paragraph 3, we revise the first sentence to delete "finding some ulnar nerve abnormality." Although Dr. Herring found some right ulnar nerve abnormality in February, his March right ulnar nerve conduction study showed no evidence of abnormality. (Ex. 9). Finally, we revise the first sentence in paragraph 4 to say that "Claimant was subsequently seen by Dr. Butters, a hand and upper extremity specialist, who diagnosed bilateral carpal tunnel syndrome, worse on the left." (Ex. 10a).

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has moved for remand to the Referee for admission of a letter from Dr. Herring, claimant's treating physician for her carpal tunnel condition, who authored four reports that are already in the record. The insurer opposes the remand request.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Evidence that is not in existence at the time of hearing is "unavailable" but may still have been "obtainable." Id. at 648.

Dr. Herring's June 7, 1994 letter presents his opinion that he properly diagnosed claimant with carpal tunnel syndrome. Although Dr. Herring's letter was not available at the time of hearing, we are not persuaded that the substantive matters discussed in that letter were not obtainable with due diligence at the time of hearing. See id., 301 Or at 648. The current record includes Dr. Herring's October 21, 1993 letter to claimant's attorney stating that he remained quite comfortable with his original diagnosis and analysis. (Ex. 19). In addition to his October 21, 1993 letter, the current record contains two other reports from Dr. Herring regarding his diagnosis, as well as another follow-up report. (Exs. 8, 9 & 15).

Under such circumstances, we consider the record to be sufficiently developed. Moreover, we conclude that there is not a compelling reason to justify remanding this case to the Referee for the taking of further evidence. Consequently, the motion to remand is denied.

Compensability

Carpal Tunnel Condition

We adopt and affirm the portion of the Referee's order regarding claimant's carpal tunnel condition with the following supplementation.

The Referee concluded that claimant had not met her burden of proving the compensability of her carpal tunnel condition. The Referee found that the insurer-arranged examinations persuasively questioned the validity of the diagnosis of carpal tunnel syndrome and cast doubt on whether claimant's condition, if she had one, was caused by her work activities.

Claimant argues that the Referee substituted his medical judgment for that of Dr. Herring when he stated that "the record does not satisfactorily identify and implicate the repetitive hand use that is deemed causative of such a condition." (O & O p. 6). We do not construe that statement as an exercise of the Referee's "medical" judgment because the Referee's conclusion is adequately supported by the record. After discussing claimant's work activities with her and reviewing the videotape, Dr. Radecki concluded that claimant's work activities did not involve tasks of a repetitive nature. (Ex. 16). Likewise, Dr. Nathan analyzed the same data and was "unable to identify any component of hand activity which would produce slowing of the median nerve * * *." (Ex. 14).

We agree with the Referee that the diagnosis of carpal tunnel syndrome is cast into considerable doubt by the insurer-arranged medical examinations. In any event, even if we assume that Dr. Herring's diagnosis is correct, claimant has not established that her work activities were the major contributing cause of her occupational disease. See ORS 656.802(2).

Dr. Herring reported that claimant's work activities "certainly could lead to the above-described conditions. She did not describe any other activities that would seem to independently be the primary cause of these conditions." (Ex. 19). First, Dr. Herring failed to discuss, in any detail, the mechanics of claimant's work activities. Dr. Herring first documented claimant's work activities in October 1993, eight months after he first examined claimant. Dr. Herring reported that claimant had described "activities involving hanging of merchandise, use of a cash register, etc." (Id).

Moreover, we understand Dr. Herring to attribute claimant's carpal tunnel condition to work activity only because such activity could have caused the condition. Thus, his reasoning is speculative, and establishes nothing more than a possibility of a causal connection. See Gormley v. SAIF, 52 Or App 1055 (1981). Claimant's burden of proof is not met unless she presents medical evidence affirmatively attributing her condition to work activities on the basis of medical probability, rather than possibility. See Miller v. SAIF, 60 Or App 557 (1982). Dr. Herring's conclusory statement that claimant's work activities "could" lead to carpal tunnel syndrome is not sufficient.

Claimant has the burden of proving that her carpal tunnel condition is compensable. See ORS 656.266. Existence of an occupational disease must be supported by medical evidence supported by objective findings. ORS 656.802(2). Based on the conclusory "possibility-based" theory expressed by Dr. Herring, as well as the countervailing opinions of Drs. Radecki and Nathan, we are persuaded that claimant has not met her burden of proving the compensability of her carpal tunnel condition.

Fibrositis/Fibromyalgia Condition

The Referee did not believe that claimant was contending that her arm and shoulder/fibrositis condition was compensable as a direct result of her previously litigated mental stress claim nor did he believe that claimant was asserting it as a consequential condition attributable to the stress claim. The Referee concluded that claimant's arm and shoulder condition was not separately caused by her work activities. Consequently, the Referee upheld the insurer's occupational disease denial.

Claimant contends that the Referee misunderstood her position. At the beginning of the hearing, claimant's attorney said that the "issue is compensability of a bilateral carpal tunnel syndrome condition and a bilateral shoulder/neck fibrosis condition * * *." (Tr. 2). Although the testimony at the hearing did not concern the stress-producing conditions at claimant's job, the medical evidence in the record is adequate for us to evaluate this issue. In light of such circumstances, we address the compensability of claimant's bilateral shoulder/fibrosis condition under the theory advanced by claimant.

Claimant argues that her neck and shoulder condition, described as fibrositis or fibromyalgia, is a compensable consequence of her compensable job-related stress claim. On June 15, 1994, we affirmed Referee Black's order that set aside the insurer's denial of claimant's occupational disease claim for her psychological condition. When a condition or need for treatment is caused by the compensable injury, 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, 415 (1992).

Claimant relies on Dr. Buchanan's reports. Claimant began seeing Dr. Buchanan in May 1992 because of her stress at work. The record indicates that claimant had developed pain in the left arm and shoulder by July 30, 1992. (Ex. 1). On October 2, 1992, Dr. Buchanan reported to the insurer that claimant's left arm complaints were an extension of her stress condition. (Ex. 6). Dr. Buchanan's December 22, 1992 chart note states that "a possibility persists that [claimant] is developing a fibromyositis type syndrome." (Ex. 1). In May 1993, Dr. Buchanan reported that claimant had developed fibromyalgia from the stress which had worsened the pain to her arms and shoulders. (Ex. 11). Dr. Buchanan explained:

> "[Claimant] currently has three diagnoses: depression, fibromyalgia and bilateral carpal tunnel syndrome. * * * The major causative factor for the fibromyalgia is the depression and job related stress." (Ex. 13; emphasis added).

The insurer relies on a notation by Dr. Carter on a vocational report in October 1992 that claimant "[h]as no physical disability. Her disability is psychiatric--major depression." (Ex. 7). The insurer asserts that claimant was referred to Dr. Carter, a psychiatrist, for treatment of stress problems. We attach little probative weight to Dr. Carter's conclusory notation. There is nothing in the record to establish that he performed a physical examination of claimant. Moreover, his notation was in response to a request to complete a physical capacities evaluation form, rather than a request for information concerning physical manifestations of her stress condition.

The insurer also relies on the opinions of Drs. Nathan and Radecki. Dr. Nathan reported that claimant had "some muscular tightness about her shoulders but there is no organic pathology related to this; it is likely of psychogenic origin." (Ex. 14). Dr. Nathan commented that if claimant's discomfort was related to her work, it should have dissipated shortly after she ceased to be employed there. (Id). The record indicates that Dr. Nathan is a hand surgeon. We do not find any evidence to establish his expertise in psychiatric matters. See Abbott v. SAIF, 45 Or App 657 (1980). Consequently, Dr. Nathan's opinion that claimant's shoulder discomfort should have dissipated after her job ended is not persuasive, especially if the fibromyalgia condition is a consequence of claimant's ongoing psychological-stress condition as opposed to her work activities per se.

Dr. Radecki reported that claimant did not have a typical fibrositis syndrome and he concluded that it would be idiopathic, if it was present. (Ex. 16). We do not find Dr. Radecki's conclusory opinion regarding claimant's fibromyalgia condition persuasive.

Unless there are persuasive reasons not to do so, we generally defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We do not find any persuasive reasons not to defer to Dr. Buchanan's opinion concerning claimant's fibromyalgia condition. As claimant's treating physician since 1992, Dr. Buchanan had a better opportunity to evaluate the progress of claimant's condition than Drs. Nathan and Radecki, who examined claimant on one occasion. We conclude that claimant has met her burden of proving that her compensable stress condition is the major contributing cause of her fibromyalgia condition.

Claimant is entitled to an assessed attorney fee for prevailing on the fibromyalgia 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 fibromyalgia issue is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by 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 December 30, 1993 is affirmed in part and reversed in part. The insurer's denial of claimant's fibromyalgia claim is set aside and the claim is remanded to insurer for processing according to law. For services at hearing and on review concerning the fibromyalgia claim, claimant's attorney is awarded $3,000, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RAYMOND A. GRAVES, Claimant
WCB Case No. 93-06471
ORDER ON REVIEW
David C. Force, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of that portion of Referee Baker's order which set aside its Notice of Closure and an Order on Reconsideration and found that claimant's low back injury claim was prematurely closed. In the event that we do not find claimant's claim prematurely closed, claimant cross-requests review of that portion of the Referee's order concerning the aggravation claim, interim compensation, and penalty and attorney fee issues. On review, the issues are premature closure, and, potentially, aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury in December 1987. He has had six back surgeries, two of which resulted in unsuccessful fusions. In December 1991, after claimant's second fusion surgery failed, claimant underwent fusion surgery with a new treating surgeon, Dr. Keizer. That procedure consisted of placing metal hardware in claimant's back. In July 1992, Dr. Keizer surgically removed the hardware.

Claimant returned for a follow-up exam on September 11, 1992. (Ex. 62-7). Dr. Keizer noted "residual pain neurogenic in the lower back and referred into the lower extremities." Id. Dr. Keizer also noted that claimant's vocational counselor had been having trouble getting claimant back to work because of his impairment. Id.

On October 21, 1992, Dr. Keizer provided SAIF with the results of claimant's exam, stating that claimant's condition had not changed since September 1992, and that claimant had reached a medically stationary status with his back fusion. (Ex. 80). Dr. Keizer also noted that claimant continued to have weakness and pain, and that claimant could only perform sedentary or sedentary/light work. SAIF closed claimant's claim on November 6, 1992 with an award of 56 percent (179.2 degrees) unscheduled permanent disability, and finding claimant medically stationary as of September 11, 1992.

Claimant had not worked since his 1987 injury. On February 22, 1993, he began an on-the-job evaluation at a sheriff's office. After working there four days, claimant was taken to the emergency room by ambulance due to pain, weakness and numbness in his legs. On February 26, 1993, Dr. Gombart, claimant's new treating physician, took claimant off work for an indefinite period of time. Dr. Gombart referred claimant to Dr. Golden, neurological surgeon. Relying on Dr. Golden's opinion, the Referee concluded that claimant was not medically stationary when SAIF closed his claim in November 1992.

Claimant has the burden of proving that his compensable condition was medically stationary at the time of claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92, 97 (1985). Claimant is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

The question of claimant's medically stationary status is primarily a medical question requiring competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981); Austin v. SAIF, 48 Or App 7 (1980). The reasonableness of medical expectations of improvement must be judged as of the date of closure, without considering subsequent changes in claimant's condition. Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985). However, medical evidence submitted after closure can be considered in determining whether claimant's claim was prematurely closed in regard to the condition at the time of closure. Scheuning v. J.R. Simplot Co., 84 Or App 622 (1987).

In May 1993, claimant was examined in a medical arbiter exam by Dr. Stanford. (Ex. 106). On July 20, 1993, Dr. Stanford stated that claimant had been medically stationary as of the time of the medical arbiter exam. Furthermore, after viewing a video provided by SAIF, Dr. Stanford also stated that it appeared that claimant's abilities were considerably greater than those he exhibited or stated he could do at the time of the arbiter exam. (Ex. 111-1).

Dr. Golden, neurological surgeon, examined claimant in April 1993. (Ex. 103-2). He opined that claimant was very badly in need of a rehabilitation program with intensive conservative management in order to restore some function to his back dynamics. Dr. Golden referred claimant for rehabilitation. On June 7, 1993, in response to an inquiry from SAIF, Dr. Golden emphasized that the major reason he referred claimant to rehabilitation was because claimant's claim was closed prematurely, and that claimant should have gone through a rehabilitation program after Dr. Keizer acknowledged that claimant had failed back syndrome. (Ex. 109).

In July 1993, Dr. Golden was provided with all of claimant's medical documents and the SAIF surveillance video. He then changed his opinion, without explanation, stating that claimant did not need rehabilitation consultation, and rescinding his opinion that claimant's claim was prematurely closed. (Ex. 112).

On October 20, 1993, Dr. Golden again changed his opinion. After reconsidering claimant's situation, he concluded that his original opinion concerning premature closure of the claim was correct. (Ex. 116-30). SAIF contends that Dr. Golden's opinion is not persuasive because it is conclusory and unexplained, and that Dr. Golden only "hoped" that further treatment would be curative. We do not agree with SAIF's contention. Dr. Golden, in fact, "hoped" that claimant's rehabilitation could be done by the doctor to whom Dr. Golden referred him. (Ex. 109-1). Dr. Golden "firmly believed" that claimant's treatment was interrupted by declaring him medically stationary. Id.

SAIF's surveillance video consists of, at most, claimant's activities over the period of four or five minutes. Furthermore, claimant's activities were obscured by vehicles and people passing in front of him. When Dr. Golden viewed the tape, he did not know that it showed claimant sitting down in a chair, rather than squatting, because Dr. Golden did not have the benefit of explanatory testimony from the hearing. (Ex. 116-16, 17).

Although Dr. Golden's impression of claimant's abilities on examination were apparently contradicted by the video, Dr. Golden testified in his deposition that claimant's symptoms were likely to wax and wane (Ex. 116-13), and that on the day of the video, claimant appeared to be having a good day. (Ex. 116-17). Furthermore, Dr. Golden explained that his reference, after examination, to "hysteric response" and "functional overlay" referred to behavior that claimant was not consciously able to control. (Ex. 116-24, 25).

Dr. Golden explained that his first change of opinion after viewing SAIF's video was, in retrospect, a little "shaky" and arbitrary. (Ex. 116-29). In light of the fact that claimant was having more back problems after claim closure, and because Dr. Golden initially formed his opinion based on claimant's failed back condition, Dr. Golden believed that his first opinion, that claimant was not medically stationary, was a reasonable opinion. Furthermore, Dr. Golden stated that he would not release a patient only two months after surgery, knowing that the patient had failed back syndrome and several previous surgeries. (Ex. 116-30). Rather, he would (and did in this case) recommend evaluation by a physical rehabilitationist. Id.

Accordingly, after our de novo review of the record, we conclude that Dr. Golden's ultimate opinion is well-reasoned, and we are persuaded by his opinion that claimant reasonably would have been expected to experience material improvement from treatment at the time his claim was closed. Therefore, we affirm the Referee's order finding claimant's claim prematurely closed.

As we have found that claimant's claim was prematurely closed, we do not reach the other issues raised by claimant as potential issues.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the premature closure issue is $1,200, 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 January 7, 1994 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
DAVID M. MORRIS, Claimant
WCB Case No. 93-06552
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Peterson's order that affirmed a Director's decision reinstating claimant's eligibility for vocational assistance. On review, the issue is vocational assistance. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The employer is seeking review of a Director's Review and Order instructing the employer to restore claimant's eligibility for vocational assistance. (Ex. 39). The pertinent facts are as follows.

After claimant was found eligible for vocational assistance, and before he became medically stationary, he returned to temporary, modified work for the employer as a security guard. The employer discovered claimant sleeping on the job and fired him. Thereafter, the employer advised claimant that his eligibility for vocational assistance had ended because he had been terminated from "suitable employment" for reasons unrelated to his injury. See OAR 436-120-050(3). Claimant requested Director review of the employer's action.

On June 2, 1993, a Director's Review and Order issued instructing the employer to reinstate claimant's eligibility and refer him for vocational assistance. The Director determined that the security guard position from which claimant was terminated was not "suitable employment" within the meaning of OAR 436-120-050(3).

The employer requested a hearing from the Director's decision. The Referee agreed with the Director's conclusion that the security job was not "suitable employment" because it would not be permanently available at a suitable wage. Accordingly, the Referee affirmed the Director's decision. The employer then requested review by the Board.

On review, the employer requests modification of the Director's decision under ORS 656.283(2)(d). That provision authorizes modification of a Director's decision if it was "characterized by abuse of discretion or clearly unwarranted exercise of discretion."

As a preliminary matter, we find that the hearing before the Referee satisfied the procedures required in a contested case, as set forth in the Court's decision in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993). Accordingly, the Referee was entitled to conduct a hearing, develop a record, find facts and determine whether the Director's order survived review. Colclasure, supra; William J. Sanchez, Jr., 46 Van Natta 371 (1994).

Turning to the merits of the case, we agree with the Referee that the pivotal issue in this case is whether claimant was employed at "suitable employment," at the time he was terminated. Furthermore, we agree that the Director properly reinstated claimant's vocational assistance. However, we base our conclusion on the following reasoning.

The Director has prescribed rules to determine eligibility for vocational assistance pursuant to ORS 656.340. See OAR 436-120-001 et seq. Pursuant to OAR 436-120-050(3), the eligibility of a worker for vocational assistance ends when the worker's "suitable employment" after the injury or aggravation ends for a reason unrelated to the injury. As explained above, the employer terminated claimant's eligibility for vocational assistance on the basis that claimant had been fired from "suitable employment" for reasons unrelated to his injury.

In Keith D. Kilbourne, 46 Van Natta 1837, on recon 46 Van Natta 1908 (1994), we found that the Director has created a distinction between determining eligibility for vocational assistance, which is controlled by OAR 436-120-005(6)(a)(A), and providing vocational assistance, which is addressed by OAR 436-120-005(6)(a)(B). In Kilbourne, we found that an initial determination of eligibility was involved, and therefore, OAR 436-120-005(6)(a)(A) applied.

Here, claimant has not been provided vocational assistance by the employer. See Lee R. Jones, 46 Van Natta 2179 (1994). (The claimant had received vocational assistance and requested Director review when the insurer refused to provide further vocational assistance. Consequently, the Board found that the case involved a situation in which vocational assistance was provided to the claimant, unlike the claimant in Kilbourne.) Furthermore, in the present case, OAR 436-120-040(7) provides that claimant is eligible for vocational assistance if, among other things, none of the "end of eligibility conditions" exist. Here, the employer advised claimant that he was no longer eligible for vocational assistance and his eligibility had ended because claimant was fired from "suitable employment" after the injury, for a reason unrelated to the injury. OAR 436-120-050(3).

Under such circumstances, because claimant had not received vocational assistance, the employer was not providing vocational assistance, and claimant is not asserting an entitlement to further vocational assistance, we conclude that this case is similar to Kilbourne, supra, and involves a determination of eligibility. Therefore, in order to determine whether claimant was working at "suitable employment" after the injury, we apply OAR 436-120-005(6)(a)(A), which defines the term "suitable employment," and provides that:

> "For the purpose of determining eligibility for vocational assistance, suitable employment includes a wage within 20 percent of the wage currently being paid for employment which is the regular employment for the worker."

There is no dispute that claimant's "regular" employment in this case was as a head rig off-bearer. Moreover, there is no dispute that the base rate for that job is $10.25 per hour. However, the employer disagrees that claimant's regular overtime (which averaged $512 per week, bringing claimant's wage to $12.80 per hour) should be added to his base hourly rate for purposes of determining claimant's suitable employment.

After reviewing the record, we find that claimant has established that he had "regular overtime" averaging $512 per week. (Ex. 39-1). At hearing, the Director's vocational consultant testified that there was "considerable overtime in (claimant's) position at the time of injury." (Tr. 45-46).

We conclude that, although there are no specific vocational rules which define what constitutes a "wage" for a worker's regular employment, it was not an abuse of discretion for the Director to include overtime in such a calculation. Here, the unrebutted testimony regarding the wage establishes that overtime was both "regular" and "considerable." There has been no evidence presented which would indicate that the overtime in this case is either sporadic or unusual, which could arguably lead to a finding that the wage for employment such as claimant's position does not include overtime.

Finally, the employer also contends that the rule requires a determination of "the wage currently being paid for employment which is the regular employment for the worker." OAR 436-120-005(6)(a)(A). (Emphasis added). The employer contends that the Director improperly considered what claimant was making at the time of the 1989 injury, rather than the current wage being paid in an off-bearer job. We conclude that, although the employer has correctly characterized the test set forth by the rule, again, there has been no evidence provided to support the employer's speculation that off-bearers currently may earn less than off-bearers employed in 1989. See e.g. Merry E. Franklin, 46 Van Natta 374, on recon 46 Van Natta 1637, on recon 46 Van Natta 1855 (1994).

Consequently, using a base wage of $12.80 per hour (claimant's base pay of $10.25 per hour, with a regular overtime average of $512 per week), claimant would have a substantial handicap to

employment. See e.g. Reyna R. Rolban-Duenez, 46 Van Natta 865, 969 (1994). Therefore, we find that the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) and (b)(B)(iii); OAR 436-120-005(6)(a)(A); OAR 436-120-005(10); OAR 436-120-040(7). Accordingly, we affirm the Director's order which found that claimant had not been terminated from "suitable employment," and therefore, claimant's entitlement to vocational assistance is reinstated.

As a result of our decision, we do not address the employer's argument concerning the issue of whether "suitable" employment must be "permanent" employment.

Because the employer requested review of this matter and we have found that claimant's compensation should not be disallowed or reduced, claimant is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $900, 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 6, 1993 is affirmed. For servics on Board review, claimant's counsel is awarded an assessed fee of $900, to be paid by the self-insured employer.

November 3, 1994 Cite as 46 Van Natta 2318 (1994)

In the Matter of the Compensation of
JOSEPH PARRY, Claimant
WCB Case No. 93-14867
ORDER ON REVIEW
Silven, Schmeits, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of Referee Mills' order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In lieu of the finding, on page 2 of the Referee's order, that "[i]n April 1993, an incident occurred off the job," we find: In March 1993, an incident occurred off the job.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, under Beck v. James River Corporation, 124 Or App 484 (1993), claimant need only establish that his accepted low back condition continues to be a material contributing cause of his current need for treatment.[1] The employer argues that Beck does not apply to this case. We agree.

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[1] The Referee also found Beck to be irreconcilable with Gray v. SAIF, 121 Or App 217 (1993). We disagree. In Beck, the Court of Appeals held that a claim for continued medical services resulting from a compensable injury is compensable if the need for treatment bears a material relationship to the compensable condition. Id. at 487. In so holding, the court stated that "ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability of a condition, i.e., to claims for new injuries or conditions different from an already accepted claim." Id. at 488.

In Gray v. SAIF, supra, the court addressed the proper analysis of a claim under ORS 656.005(7)(a)(B). The court concluded that, when a claimant's preexisting condition combines with a compensable injury to cause her disability and need for treatment, the claimant must show that the compensable injury was the major contributing cause of the disability and need for treatment. Id. at 219.

We find no conflict between the holdings in Beck and Gray. The former was a medical services claim for an already accepted condition governed by ORS 656.245(1), whereas the latter concerned the determination of compensability of a resultant condition claim under ORS 656.005(7)(a)(B).

The primary issue presented by the present case is whether the parties litigated this matter as a resultant condition claim or as a medical services claim. If it is the former, claimant must prove that his current condition resulted from his accepted low back condition and that the accepted condition was and remains the major contributing cause of his current low back condition. ORS 656.005(7)(a)(B); Gray v. SAIF, supra n.1. If it is the latter, claimant need only establish that his accepted condition materially contributed to his current need for medical services. ORS 656.245(1); Beck v. James River Corp., supra.

Claimant sustained a compensable low back injury in 1992. The employer accepted the claim. Thereafter, in March 1993, claimant twisted his back during an off-work incident. He required additional medical treatment. Claimant was subsequently examined by Drs. Logan and Reimer on the employer's behalf. They concluded that claimant had preexisting degenerative changes in his lumbar spine. (Ex. 10-4). Dr. Logan thereafter concluded that claimant's 1992 work injury had combined with the preexisting degenerative changes to cause or prolong his need for treatment. (Ex. 12-1). Logan further concluded that the major contributing cause of claimant's current need for treatment was his preexisting degenerative condition. (Id. at 2). Dr. Higgins, treating physician, concurred with Dr. Logan's reports. (Exs. 12, 14).

Claimant sent the employer a letter seeking claim forms for "aggravation benefits." (Ex. 13).[2] Thereafter, the employer issued its denial, which stated that it "hereby denies compensability of your current condition as our accepted injury is no longer the major contributing cause of your current disability and need for medical treatment." ((Ex. 15-1). At hearing, in outlining the issues, the Referee stated that the employer "denies compensability of Claimant's low back condition and that it's a work related condition." (Tr. 2).[3]

On the basis of this evidence, we conclude that the parties' dispute concerned the compensability of claimant's current low back condition (and ensuing need for treatment), not the compensability of continuing medical treatment related to claimant's accepted low back condition. Accordingly, we conclude that the parties were litigating this matter as a resultant condition claim, and not as a medical services claim. Compare Larry D. Johnson, 46 Van Natta 440 (1994) (Board unable to determine whether parties litigating matter as medical services or consequential or resultant condition claim). To prevail, therefore, claimant must satisfy ORS 656.005(7)(a)(B)'s major contributing cause standard.

We conclude that claimant has not met that standard. As stated earlier, both Drs. Logan and Higgins concluded that the major contributing cause of claimant's current disability and need for treatment was an underlying degenerative disc condition. (Exs. 12, 14). Because that evidence does not satisfy claimant's burden under ORS 656.005(7)(a)(B), we conclude that he had failed to establish the compensability of his current low back condition. Accordingly, we reverse the Referee's decision setting aside the employer's denial of that condition.

ORDER

The Referee's order dated April 13, 1994 order is reversed. The self-insured employer's denial is reinstated and upheld in its entirety. The Referee's attorney fee award is also reversed.

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[2] In his order, the Referee stated that claimant was not pursuing an aggravation claim. Claimant does not contest that statement.

[3] Claimant's counsel added that "[t]he medical treatment under the current compensability [sic] is part of the issue * * *." (Tr. 3). The Court of Appeals has held that carriers are bound by the express language of their denials. Tattoo v. Barrett Business Services, 118 Or App 348, 351 (1993). The employer's denial is couched in terms of ORS 656.005(7)(a)(B). Therefore, we conclude that, in the absence of a concession by the employer redefining the issue at stake as a medical services dispute, claimant's counsel's statement regarding the medical treatment issue did not operate to convert the issue being litigated from a resultant condition claim to only an ORS 656.245(1) medical services claim.

In the Matter of the Compensation of
ROBERT E. CROSSE, Claimant
WCB Case No. 93-00089
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Neal's order that: (1) upheld the self-insured employer's "de facto" denial of claimant's occupational disease claim for major depression; (2) upheld the employer's "de facto" denial of claimant's anal fissures and gastrointestinal condition; and (3) awarded a $3,000 attorney fee pursuant to ORS 656.386(1). The self-insured employer cross-requests review of that portion of the order awarding a $3,000 attorney fee. On review, the issues are compensability 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

Compensability of Major Depression

In February 1991, claimant sought treatment from Dr. Quick, psychologist, for depression. In July 1991, Dr. Risser, family physician, prescribed antidepressant medication for claimant. Claimant was released from work. In October 1991, claimant returned to work but, in March 1992, permanently left work. In October 1992, claimant began treating with Dr. Soule, psychiatrist. In December 1992, the employer accepted a claim for adjustment disorder with mixed emotional features. Eventually, claimant moved to Arizona.

At hearing, claimant asserted that, rather than an adjustment disorder, the employer should have accepted the claim as one for major depression. The Referee disagreed, finding more persuasive the medical evidence that the more appropriate diagnosis for claimant's condition was an adjustment disorder. Claimant challenges this conclusion, relying on medical opinion from his treating physicians.

The diagnosis of adjustment disorder is supported by Dr. Freehill, psychiatrist, Dr. Turco, psychiatrist, and Dr. Goranson, psychiatrist. Dr. Freehill examined claimant once at Dr. Risser's referral. In the absence of formal testing, Dr. Freehill's diagnosis was "deferred", but he indicated a "probable adjustment disorder with mixed emotional features." (Ex. 21-3).

Dr. Turco examined claimant on behalf of the employer. Dr. Turco found that claimant had an adjustment disorder with mixed emotional features as well as passive dependent and hysterical personality traits. (Ex. 23-14). In a subsequent report, Dr. Turco disputed the appropriateness of the diagnosis of a major depression, stating that claimant did not have such a condition at the time of his examination and, if he subsequently developed it, it would be related to litigation or personal issues rather than work. (Ex. 31-1). In a third report, Dr. Turco found that information that claimant currently was not experiencing symptoms of depression was consistent with the diagnosis of a resolved adjustment disorder. (Ex. 38).

Dr. Goranson performed a record review at the employer's request and agreed with Dr. Turco's diagnosis. In particular, he found that "the facts of the case, particularly the outcome," confirmed the diagnosis of adjustment disorder since such a condition by definition remitted soon after cessation of the initiating stressor and claimant's condition had resolved following his move to Arizona. (Ex. 40-3).

Based on claimant's symptoms, test results, and his contact with claimant through treatment, Dr. Quick found that claimant's condition fit the diagnosis of major depression. In particular, Dr. Quick found that claimant had five of the eight symptoms listed in the DSM-III-R for major depression. (Ex.

36-2). Because the DSM-III-R also provided that the diagnosis of adjustment disorder should not be used if the disturbance met the criteria for another disorder, Dr. Quick found that such a diagnosis was not appropriate.

Dr. Soule also diagnosed major depression. (Ex. 29).

We first note that the employer also relies on Dr. Risser's diagnosis of acute anxiety depression, asserting that it supports the position that claimant's psychological condition was transitory and, thus, more consistent with an adjustment disorder. We find Dr. Risser's diagnosis to have little relevance. First, there is no evidence that Dr. Risser has any training or expertise in psychological matters. Furthermore, there is no medical evidence interpreting Dr. Risser's use of the diagnosis of "acute anxiety depression" and whether it is more consistent with "adjustment disorder" or "major depression." Therefore, we find that it supports neither diagnosis.

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). We do so here. Dr. Quick extensively treated claimant and provided a well-reasoned opinion supporting his diagnosis of major depression. Dr. Soule also diagnosed claimant with major depression. Although Dr. Soule provided little reasoning, he became claimant's treating psychiatrist in October 1992. Thus, both Dr. Quick and Dr. Soule had substantially more contact with claimant than Dr. Freehill and Dr. Turco, both of whom examined claimant one time, and Dr. Goranson, whose review was limited to the record.

Furthermore, Dr. Turco and Dr. Goranson essentially relied upon information that claimant was no longer suffering symptoms of depression after moving to Arizona in finding that claimant had an adjustment disorder. The record contains evidence, however, that claimant experienced depression subsequent to his move and was on antidepressant medication. (Ex. 42-5). Finally, we find the persuasiveness of Dr. Freehill's opinion to be limited since he indicated that his diagnosis was "deferred" and was in the absence of test results.

Therefore, we conclude that the more persuasive evidence shows that claimant's condition was one of major depression. Inasmuch as the diagnosis of claimant's condition was the only contested element of ORS 656.802(2), we conclude that claimant proved the compensability of his major depression condition.

Compensability of Anal Fissure

Claimant asserts that he proved the compensability of his anal fissure by showing that such condition was caused by work stress. We first note that, in determining the standard for analyzing compensability, we look to the condition for which compensation is sought rather than the cause of the condition. Mathel v. Josephine County, 319 Or 235 (1994).

Here, the only evidence of causation shows that the anal fissure resulted from trauma. (Ex. 4-2). Thus, we find no proof that work activities contributed to the condition. Accordingly, whether analyzed as an injury or occupational disease, we conclude that claimant failed to prove the compensability of the anal fissure. See ORS 656.005(7)(a), ORS 656.802(2).

Compensability of Gastrointestinal Condition

We adopt and affirm that portion of the Referee's order regarding the gastrointestinal condition.

Attorney Fees

The Referee awarded claimant an attorney fee of $3,000 under ORS 656.386(1) for the employer's pre-hearing acceptance of the adjustment disorder. Claimant asserts that he is entitled to an award of $10,521 for services at hearing. The employer contends that the Referee's award should be reduced by half.

We affirm the Referee's attorney fee award under ORS 656.386(1). See OAR 438-15-010(4). Furthermore, inasmuch as claimant finally prevailed over the employer's "de facto" denial of the claim

for major depression, his attorney is entitled to an assessed fee for services concerning the compensability of such condition. 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 counsel's services at hearing and on review regarding this issue is $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record, claimant's appellate briefs, and claimant's counsel's statement of services), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant is not entitled to a fee for services regarding the compensability of the anal fissure and gastrointestinal condition or the attorney fee issue.

ORDER

The Referee's order dated January 19, 1994 is reversed in part and affirmed in part. That portion of the order finding claimant's major depression condition not compensable is reversed. The self-insured employer's "de facto" denial of major depression is set aside and the claim is remanded for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the compensability of the major depression issue, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CHARLES CHAPMAN, Claimant
WCB Case No. 93-05128
ORDER ON REVIEW (REMANDING)
James L. Edmunson, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Referee McWilliam's order awarded temporary partial disability (TPD) between March 1, 1993 and July 20, 1993. On review, the issue is temporary disability. We remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Following his compensable injury, claimant returned to work for his employer performing modified duties. His wages were not affected by the change in his work assignment. As of March 1, 1993, claimant was terminated from his employment for violation of the employer's drug policy. The employer did not pay temporary disability after claimant's discharge.

The Referee found that claimant was eligible for TPD beginning with his March 1, 1993 termination until the July 20, 1993 claim closure. Noting that claimant left work for reasons unrelated to his injury, the insurer contends that claimant is not entitled to temporary disability.[1]

Since the Referee's order, the court issued its decision in Stone v. Whittier Wood Products, 124 Or App 117 (1993). In Stone, as reconsidered, 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 (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.

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 the Board's application of OAR 436-60-030(2) improperly restricted the claimant's 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).

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

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[1] The insurer argues that nothing in Stone entitles workers to TPD if they have lost their jobs for non-injury related reasons. In support of this contention, the insurer notes that, on reconsideration of its initial "vacated" opinion, the Stone court incorporated and adopted its prior discussion and holding that claimants are not entitled to TPD. We disagree with the insurer's interpretation of the Stone decision.

To begin, the Stone court expressly incorporated its previous holding that "the Board was not required to determine whether [the claimant's] discharge violated ORS 659.425 before deciding her eligibility for TPD." The Stone court did not refer to its prior conclusion that claimant was not entitled to temporary disability because she had been terminated for reasons unrelated to her compensable injury and she was receiving wages equal to or greater than her pre-injury wages. In light of such circumstances, we do not agree that the Stone court implicitly adopted this latter unmentioned portion of its expressly "vacated" earlier opinion.

In addition, the Stone court's reasoning on reconsideration directly conflicts with its holding in its earlier decision. Specifically, reasoning that TPD must be determined based on a loss of "earning power" at any kind of work, the Stone court reasoned on reconsideration that, depending on the circumstances, a claimant's post-injury wages may be of great, little, or no importance. Inasmuch as claimant's post-injury wages were determinative in calculating TPD in its earlier opinion, the insurer's argument that the Stone court's decision on reconsideration did not alter that prior holding cannot be sustained.

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.

We applied the Stone holding in Troy Shoopman, 46 Van Natta 21 (1994). See also Babette Stone, 46 Van Natta 1191 (1994). In Shoopman, as in the present case, after returning to modified work, a claimant was terminated for violation of a drug policy. Inasmuch as the Shoopman claimant's "post-injury" wages equalled his wages at his "at-injury" job, TPD was calculated at "zero" under the Director's then existing OAR 436-60-030(2). In light of Stone, we reasoned that the claimant's TPD cannot be calculated based solely on actual wage loss, if any, on returning to work, but rather must be determined based on the proportionate loss of earning power at any kind of work. Finding the record regarding the claimant's "earning power at any kind of work" to be insufficiently developed and since the parties in Shoopman had not had an opportunity to develop that record because the Stone decision had issued subsequent to their hearing, we held that there was a compelling reason to remand for further evidence taking.

Here, as in Shoopman, the record is devoid of evidence 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 after his job termination caused a proportionate loss of earning power at any kind of work. See Babette Stone, supra; Troy Shoopman, supra.

Furthermore, considering that 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, we find that there is a compelling reason to remand for the submission of additional evidence. See ORS 656.295(5); Babette Stone, supra; Troy Shoopman, supra.

Accordingly, we vacate the Referee's order dated August 26, 1993. This matter is remanded to Referee McWilliams for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER E. EISTERHOLD, Claimant
WCB Case No. 94-00744
ORDER ON REVIEW
Johnson, Cram, et al., Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Livesley's order which set aside its denial of claimant's eye and head injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of his employment. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following corrections. The van, which was being driven by the juveniles, did not enter the employer's parking lot. Rather, the paint ball was fired from the van as it drove by the employer's lot.

CONCLUSIONS OF LAW AND OPINION

Applying the seven-factor work-related test enunciated in Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985), the Referee found that claimant's injuries were sufficiently work-related to establish compensability. The Referee further found that claimant's

conduct was neither an assault nor such deviation from his duties as to preclude a finding of compensability under ORS 656.005(7)(b)(A). We find that claimant was acting outside the course and scope of his employment, and, therefore, conclude that claimant's injury is not compensable.

The seven factors outlined by the court in Mellis are: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Griswold, supra. Claimant need not satisfy every factor, nor is a single factor dispositive. Preston v. SAIF, 88 Or App 327 (1987). Rather, to establish compensability, claimant must ultimately prove that "the relationship between the injury and the employment is sufficient that the injury should be compensable." Rogers v. SAIF, 289 Or 633 (1980).

In addition to the above guidelines, as a general rule, an employee who performs an act outside of his regular duties which is undertaken in good faith to advance the employer's interest is within the course of employment. Not every act, however, which benefits the employer is in the course of employment and, therefore, compensable. For instance, although advancing the employer's interest, the act may be outside the reasonable bounds of employment or expressly prohibited by the employer. Dave G. Owens, 43 Van Natta 2680 (1991)(citing 1A Larson, Workmen's Compensation Law 27.13-27.14 (1979)).

Here, claimant's customary job duties included opening and closing the store, janitorial work, and if necessary, removing vagrants from the premises. Claimant received extra pay for performing extra duties, such as occasionally sweeping the parking lot.[1] Claimant had been directed by the employer not to engage in physical altercations with persons who might come on the premises and if there was any problem, he was to call the police.

Claimant was sweeping the employer's parking lot at approximately 10:30 p.m., when juveniles drove by and shot a paint ball at claimant striking him on the back. Claimant was not hurt by the paint ball. Claimant ran after the van about half a block when his head hit the rear window breaking the glass.[2] Claimant testified that his intentions for running after the van were to get the license plate number and possibly talk to the occupants in the van. With the information provided by claimant, the police were able to apprehend and convict the juveniles involved. However, when claimant chased the van he acted outside the reasonable bounds of employment. Moreover, such conduct was expressly prohibited by the employer and constituted a distinct departure on a personal mission.

Upon considering the facts and the seven Mellis factors listed above, we conclude that, although claimant's activity benefitted the employer by identifying possible vandals, claimant exceeded the reasonable bounds of his employment when he pursued the van. Although the employer had an interest in the safety of his employee, that interest did not include contemplating or expecting the employee to pursue his assailants. Claimant's customary job duties did not entail chasing after the van no matter claimant's intended purpose in doing so. Moreover, claimant's activity was so inconsistent with the employer's directives as to constitute a distinct departure on a personal mission. See Proctor v. SAIF, 123 Or App 326, 332 (1993). In sum, we find that claimant failed to show a sufficient relationship between his injury and his employment to establish compensability.

ORDER

The Referee's order dated April 29, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,650 assessed attorney fee is also reversed.

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[1] We find the fact that claimant was paid during the time of his injury is not dispositive.

[2] Claimant was uncertain whether the van had backed up in an effort to scare him away. Regardless of whether the van, in fact, backed up, claimant's closeness to the van suggests that his intentions were more than merely obtaining the license plate number.

In the Matter of the Compensation of
STEVEN S. EWEN, Claimant
WCB Case No. 91-07052
ORDER ON REMAND
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Food Services of America v. Ewen, 130 Or App 397 (1994). The court has reversed our prior order, Steven S. Ewen, 45 Van Natta 207 (1993), which had held that the self-insured employer was required to pay temporary disability based on an authorization from a non-attending physician. Inasmuch as only an attending physician can authorize the payment of temporary disability under ORS 656.245(3)(b)(B), the court has concluded that the non-attending physician's authorization could not trigger the employer's obligation to pay temporary disability. Consequently, the court has remanded for reconsideration.

In light of the court's conclusion, it follows that claimant is not entitled to receive temporary disability commencing October 5, 1990.[1] Accordingly, on reconsideration, we affirm the Referee's order dated November 4, 1991 that declined to award temporary disability or assess penalties for allegedly unreasonable claim processing.

IT IS SO ORDERED.

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[1] We further note that, on October 10, 1994, we approved the parties' Claim Disposition Agreement (CDA), in which claimant released all past, present, and future rights to benefits (including temporary disability), except medical services, for his compensable injury. Since the issues in this case either directly or indirectly pertain to claimant's entitlement to temporary disability (a benefit that claimant has released under the approved CDA), we also conclude that claimant is not entitled to additional temporary disability or any accompanying penalties.

In the Matter of the Compensation of
DENNIS G. KITCHEN, Claimant
WCB Case Nos. 93-07923 & 93-06130
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Barrett Business Services (Barrett), a self-insured employer, requests review of Referee Mongrain's order that: (1) set aside its denial of claimant's low back condition; (2) upheld the denial issued by Bear Creek Corporation (Bear Creek), a self-insured employer, for the same condition; and (3) awarded claimant an assessed attorney fee against Barrett. On review, the issues are compensability, responsibility, and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant twisted and struck his right hip on a metal bar while working for Barrett on January 29, 1993. Dr. Korpa, an osteopathic physician, initially treated claimant. Dr. Korpa noted pain across the iliac spine and pain and numbness throughout the right hip, buttock, and lateral aspect of the leg and calf. Dr. Korpa diagnosed only a right hip contusion, which Barrett accepted as nondisabling. The claim was closed on March 23, 1993.

Claimant's pain lessened, but never resolved. On March 2, 1993, claimant began working for Bear Creek. After working a 15-hour shift on March 30, 1993, claimant's symptoms of low back pain and pain and numbness radiating into the right leg worsened. A symptomatic spondylolisthesis was diagnosed.

Both Barrett and Bear Creek denied compensability and responsibility for claimant's symptomatic spondylolisthesis. At hearing, claimant identified the issues as the employers' compensability denials. Barrett then clarified that it was only denying responsibility. Bear Creek continued to deny both compensability and responsibility. Asserting that both employers had initially denied compensability, claimant requested an attorney fee, payable by whichever employer was found responsible for claimant's low back condition.

Claimant did not have symptoms of spondylolisthesis prior to January 29, 1993. Claimant's current condition is the same condition that it has been since the original injury accepted by Barrett. Claimant did not sustain a new compensable injury while working for Bear Creek.

CONCLUSIONS OF LAW AND OPINION

In its respondent's brief, Bear Creek discusses only responsibility. We note, however, that Bear Creek identifies the issues on review as both the compensability of, and responsibility for, claimant's low back condition. Therefore, we find that Bear Creek has not conceded compensability. Consequently, we address both compensability and responsibility on review.

Compensability

The medical evidence establishes that claimant had preexisting asymptomatic spondylolisthesis. Claimant's current disability and need for medical treatment are due to a combination of his preexisting condition and work injuries. Accordingly, the "resultant" condition is compensable only to the extent the compensable injury is the major contributing cause of the disability or need for medical treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993). Where a compensable injury is the major contributing cause of a preexisting condition becoming symptomatic, the "resultant" condition is compensable. U-Haul of Oregon v. Burtis, 120 Or App 353, rev den 318 Or 26 (1993).

Moreover, although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the resultant condition, that is not necessarily always true. Determining major contributing cause under ORS 656.005(7)(a)(B) involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See Dietz v. Ramuda, 130 Or App 397 (1994) (citing McGarrah v. SAIF, 296 Or 145 (1983), Dethlefs v. Hyster Co., 295 Or 298 (1983), and Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992)). After our review of the record, we find claimant has proven that the January 1993 work injury with Barrett is the major cause of his preexisting spondylolisthesis becoming symptomatic.

In reaching this conclusion, we rely on the medical opinion of examining neurosurgeon Rosenbaum, as supported by attending physician Peterson and former attending physician Versteeg. Dr. Rosenbaum consistently opined that claimant had an asymptomatic congenital spondylolisthesis that was transformed into a symptomatic spondylolisthesis by the January 1993 injury with Barrett. Similarly, Dr. Peterson opined that the major contributing cause of claimant's spondylolisthesis becoming symptomatic was the January 1993 injury. Finally, Dr. Versteeg agreed that claimant's radiculopathy symptoms are related to the spondylolisthesis that was aggravated by claimant's employment with Barrett. We find Drs. Rosenbaum, Peterson and Versteeg's well-reasoned medical opinions persuasive. See Somers v. SAIF, 77 Or App 259, 262 (1986).

In addition, although Drs. Korpa and Naugle are unable to relate claimant's spondylolisthesis to the January 1993 work injury, Dr. Korpa agrees that claimant's symptoms were consistent with symptomatic spondylolisthesis, and Dr. Naugle agrees that claimant's symptoms might have been consistent with spondylolisthesis. The preponderance of the medical evidence establishes that claimant's symptomatic spondylolisthesis is compensable. See ORS 656.005(7)(a)(B); Dietz v. Ramuda, supra; Tektronix, Inc. v. Nazari, supra; U-Haul of Oregon v. Burtis, supra.

Responsibility

We adopt the Referee's reasoning and conclusion that Barrett is responsible for claimant's symptomatic spondylolisthesis, with the following comment.

Contending that claimant's symptomatic spondylolisthesis has never been accepted, Barrett argues that the Referee erred in applying ORS 656.308(1) to find it responsible for claimant's current low back condition. Barrett reasons that because claimant's current compensable symptomatic spondylolisthesis condition is not the "same condition" determined to be compensable under its January 1993 claim, responsibility should be determined under the last injurious exposure rule. We disagree.

ORS 656.308 expressly applies to "compensable" conditions (i.e., conditions related to the compensable injury) and is not limited to "accepted" conditions. Gloria C. Garcia, 45 Van Natta 1702, 1703, n.1 (1993). The persuasive medical opinions establish that claimant's symptomatic spondylolisthesis is the "same condition" represented by claimant's compensable January 1993 injury with Barrett, even though different medical terminology has been employed. See Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993). Thus, ORS 656.308(1) applies.

Applying ORS 656.308(1), Barrett remains responsible for future medical services and disability relating to the low back condition unless claimant sustains a new compensable injury involving the same condition that is the major contributing cause of disability or need for treatment. SAIF v. Drews, 318 Or 1 (1993). Although claimant's pain symptoms worsened while working for Bear Creek, based on Dr. Rosenbaum's persuasive opinion, we find that the major contributing cause of claimant's current low back condition is the accepted January 29, 1993 injury at Barrett's, not the March 30, 1993 incident at Bear Creek's. Accordingly, because the record does not establish that claimant sustained a "new compensable injury" within the meaning of ORS 656.308(1), Barrett remains responsible for claimant's symptomatic spondylolisthesis. SAIF v. Drews, supra.

Attorney Fees

On review, Barrett contends that, because claimant failed to raise the issue of attorney fees specifically against it, the Referee erred in ordering Barrett to pay the assessed attorney fee. We understand Barrett to argue that claimant has failed to preserve his right to request an assessed fee against Barrett, and we disagree. See Frank P. Heaton, 44 Van Natta 2104 (1992) (attorney fee is natural derivative of compensability determination). Moreover, on this record, we conclude that claimant adequately raised the issue of his entitlement to an attorney fee related to Barrett's denial when he requested that the Referee award an attorney fee payable by the responsible employer. Accordingly, we reject Barrett's argument.

Barrett further asserts that, because Bear Creek continued to deny compensability at hearing (whereas Barrett conceded compensability at hearing), Bear Creek put claimant's right to compensation at risk and, therefore, should be liable for the assessed attorney fee. We affirm the Referee's attorney fee assessment against Barrett.

Although by the time of hearing only Bear Creek continued to contest the compensability of claimant's low back condition, initially, Barrett denied compensability and responsibility. As the Referee upheld Bear Creek's denial, we conclude that the Referee's award of an attorney fee against Barrett pursuant to ORS 656.386(1) for finally prevailing over the compensability portion of Barrett's denial was appropriate. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant's counsel entitled to a carrier-paid fee under ORS 656.386(1) where carrier had rescinded compensability portion of its denial before a hearing regarding responsibility for the claim); Dale A. Karstetter, 46 Van Natta 410 (1994).

Finally, claimant is entitled to an assessed attorney fee for prevailing over Barrett's request for review. ORS 656.382(2). Because Bear Creek denied compensability at the time of the hearing and the Referee's order addresses compensability, claimant's compensation remained at risk on review. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993); Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). However, since Barrett requested Board review and we did not reduce or disallow claimant's compensation, Barrett is responsible for the assessed attorney fee award for services on review. See ORS 656.382(2); Cigna Insurance Companies v. Crawford and Co., supra; William J. Emery, 45 Van Natta 1521, on recon 45 Van Natta 1777 (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 service on review is $500. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent brief), the complexity of the issues, and the value of the interest involved. No attorney fee is available for that portion of claimant's brief devoted to the attorney fee issue. Martin E. Mendez-Esquibel, 45 Van Natta 959 (1993); see Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated April 5, 1994 is affirmed. For services on review, claimant's counsel is awarded $500, to be paid directly to claimant's attorney by Barrett Business Services.

November 7, 1994 Cite as 46 Van Natta 2329 (1994)

In the Matter of the Compensation of
LAURIE L. McKINLEY, Claimant
WCB Case No. 91-17095
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Barber's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a fibromyalgia condition. In her brief, claimant moves to strike portions of Dr. Voiss' testimony. On review, the issues are motion to strike and compensability. We deny the motion and reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

On review, claimant contends that the Referee abused his discretion in permitting Dr. Voiss to testify regarding the Rorschach and MMPI tests because the underlying data had not been supplied by SAIF to claimant prior to hearing. Claimant requests that Dr. Voiss' testimony and report regarding the two tests be stricken from the record.

Carriers are required to disclose copies of all relevant claim documents to the claimant prior to hearing. OAR 438-07-015. According to Dr. Voiss' testimony, he did not provide to SAIF the underlying data supporting his report, including the results of the Rorschach test and MMPI. (Tr. Day 3, 128-29 and 139). Therefore, because SAIF was not furnished with such data, it could not have provided the test results to claimant by means of the normal discovery process. Thus, we find that SAIF did not fail to comply with OAR 438-07-015.

Furthermore, claimant withdrew her objection to Dr. Voiss' testimony regarding the Rorschach test when assured by the doctor that the test was administered by an expert. (Tr. Day 3, 132). Claimant did not request that the underlying data, which Dr. Voiss brought to the hearing, be admitted by the Referee, nor did she indicate that she was materially prejudiced by its nondisclosure. Furthermore, she did not request that the Referee continue the hearing to give Dr. Bennett an opportunity to evaluate the data. Consequently, we conclude that claimant did not present any circumstances that indicate that the Referee abused his discretion. See ORS 656.283(7); OAR 438-07-018(4). Accordingly, we deny claimant's motion to strike.

Compensability

Applying SAIF v. Hukari, 113 Or App 475, rev den 314 Or 391 (1992), the Referee concluded that claimant's occupational disease claim for stress-induced fibromyalgia was not compensable. In Hukari, the court held that any claim that a condition is independently compensable because it was caused by on-the-job stress must be treated as a mental disorder claim under ORS 656.802(3). The Referee found that claimant failed to proved compensability because she did not establish a mental disorder claim.

Subsequent to the Referee's order, the Supreme Court issued Mathel v. Josephine County, 319 Or 235 (1994). In Mathel, the Court considered whether the claimant's claim for a heart attack properly was analyzed as an accidental injury or occupational disease. The Court noted that, generally, workers make claims for accidental injuries or occupational diseases and not for their causes. Id. at 242. The Court further found that ORS 656.005(7) referred to "events" and ORS 656.802 referred to "ongoing conditions or states of the body or mind." Finding that a heart attack was an "event," the Court held that, whether caused by physical exertion, on-the-job stress, or both, a heart attack was an accidental injury within the meaning of ORS 656.005(7)(a) rather than a mental disorder under ORS 656.802(3). Id. at 242-43.

In DiBrito v. SAIF, 319 Or 244 (1994), another decision issued subsequent to the Referee's order, the Court expanded on its Mathel holding. In DiBrito, the claimant sought compensation for an episode of colitis and a personality disorder. The Court agreed with the Board's application of ORS 656.802 to the claim for the personality disorder. Id. at 249. However, citing Mathel, the Court further held that the Board erred in not analyzing separately the claim for colitis under ORS 656.005(7), explaining that, whether caused by physical factors, by job stress, or by both, the episode of colitis was an "event" constituting an accidental injury. Id. at 248-49.

Based on Mathel and DiBrito, in determining the appropriate standard for analyzing compensability, we focus on whether claimant's fibromyalgia was an "event" under ORS 656.005(7) or an "ongoing condition or state of the body or mind" under ORS 656.802; the cause of claimant's condition is not material to this inquiry. The record shows that claimant's fibromyalgia symptoms were gradual in onset. (Ex. 38). Therefore, we find that claimant's condition was not an "event" and more similar to a "state of the body," constituting an occupational disease. Accordingly, to carry her burden, claimant must establish that her work exposure was the major contributing cause of her fibromyalgia condition or its worsening. ORS 656.802(2).

SAIF argues that claimant's complaints arose from her emotional and psychological problems, not from her working conditions. The causation of claimant's fibromyalgia is a complex medical question, the resolution of which turns on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986); Uris v. Compensation Dept., 247 Or 420 (1967). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or app 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983).

Here, the medical evidence concerning causation is provided by Dr. Bennett, Director of the OHSU Division of Arthritis and Rheumatic Diseases, and Dr. Voiss, psychiatrist.[1]

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[1] The remainder of the evaluations were provided by psychiatrists, who, with the exception of Dr. Voiss, did not directly address claimant's fibromyalgia condition.

Dr. Turco diagnosed claimant with mixed personality disorder with elements of somatization, hysteria (conversion of psychological issues to physical complaints), and chronic depression, none of which he related to claimant's work. (Ex. 42). He did not expressly address claimant's fibromyalgia syndrome.

Dr. Goranson also opined that the majority of claimant's psychological problems were a result of somatization disorder, which arose out of claimant's developmental history. He performed no physical examination and had no comment on her fibromyalgia. (Ex. 50-19, Tr. 160).

Dr. Ochoa opined that claimant's complaints were modulated by an obvious psychological overlay. He recommended a psychological-psychiatric assessment and a muscle biopsy of a trigger point to clarify the mechanisms behind claimant's complaints. (Ex. 50A-11, 50A-12). Several psychiatric assessments had been performed, including that by Dr. Wiens in conjunction with claimant's admission to the OHSU fibromyalgia program.

Dr. Bennett explained that fibromyalgia syndrome is a descriptive clinical condition characterized by the presence of diffuse musculoskeletal pain and multiple tender areas. The exact mechanism underlying the pain is not known. Additional findings may include morning stiffness, sleep disturbance, vascular reactivity, functional urinary and GI tract abnormalities, and a history of psychiatric disorders. (Exs. 7-3, 7-4 and 53). After evaluation of her complaints by Drs. Campbell and Wiens, claimant was diagnosed with fibromyalgia, Somatization, and Major Depressive Episode. Claimant is not making a claim for her diagnosed psychological conditions. Dr. Bennett made objective findings of trigger points, sleep disturbance, and low levels of Somatomedin-C, all diagnostic of fibromyalgia. As a result, claimant was accepted into the fibromyalgia treatment program. (Exs. 45-2, 27-2, 27-4 and 32A).

Dr. Bennett, who treated claimant from September 30, 1991 through March 30, 1992 for her fibromyalgia and depression, opined that the major contributing cause of her current conditions resulted from increasing pressure and conflicts at work at the DFW. He noted that claimant had been functioning well and had not had any major medical problems prior to 1990. (Ex. 41).

Dr. Voiss' opinion is not persuasive on the issue of causation. He opined that fibromyalgia does not exist as a pathological entity and that claimant had no physical condition. Instead, he opined that claimant's physical problems were all psychological problems. (Ex. 51-3; Day 3, Tr. 147; Day 3, Tr. 154). We are persuaded by Dr. Bennett's opinion that claimant suffered from fibromyalgia, as documented by his objective findings of trigger points, sleep disturbance, and low levels of Somatomedin-C, noted above.

SAIF argues that, given claimant's extensive documented medical history, Dr. Bennett's statement that claimant had "not had any major medical problems prior to 1990," indicates that his conclusion is based on faulty history. We disagree.

Dr. Bennett reviewed Dr. Turco's and Dr. Ochoa's psychiatric reports (See Exs. 42, 45-1, 50A and 53), which set forth claimant's work-related and non-work-related stressors. He explained that patients who have chronic pain (as claimant did with her headaches and TMJ, for which she sought treatment in January 1990, see Exs. 11, 12, 14, 15, 17, 22) and who then develop some of the psychological sequelae of the pain, are often more susceptible to stress. Thus, Dr. Bennett opined, the problems claimant encountered at work had a major impact on the evolution of her fibromyalgia. (Exs. 9, 45-2, 47A and 49).

Considering Dr. Bennett's accurate history, his advantage as claimant's treating physician, and his well-reasoned opinion, we find no persuasive reason to discount his conclusion that claimant's work activities contributed to her fibromyalgia. See Weiland v. SAIF, supra. Further considering that claimant's susceptibility to stress-caused fibromyalgia does not weigh against her claim, we conclude, based on Dr. Bennett's opinion, that claimant has carried her burden of proof. See Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991). Consequently, the claim is compensable. See ORS 656.802(2).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $5,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and the appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 9, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $5,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LOUIE J. PLUMLEE, Claimant
WCB Case No. 93-01923
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Mary Oldham, the alleged employer (hereinafter "Oldham"), requests review of Referee Spangler's order which set aside a Director's order that found claimant was not a subject worker. In his brief, claimant seeks an attorney fee award. On review, the issues are subjectivity 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

Subjectivity

Claimant and Oldham entered into a lease agreement for a commercial building in which claimant intended to build boats. The building required substantial demolition and remodeling, which claimant agreed to do, before it was suited for claimant's needs. Therefore, according to the lease agreement, claimant was not required to pay rent for two months while the remodeling was in progress. (Ex. 1-1, 1-2). The lease agreement also provided that Oldham was responsible for repairs to the roof, but roof repairs were not contemplated as a part of the remodeling project. (Ex. 1-3).

After beginning the remodeling project, claimant discovered the roof was leaking through several skylights. Oldham was not able to make the repairs. Claimant refused to do the work in lieu of rent because rent was already suspended pending remodeling. Consequently, Oldham agreed to pay claimant and another person ten dollars each per hour to repair the leaking roof. (Tr. 61). After working a total of 15 hours, claimant fell and injured his right wrist and thumb. (Tr. 69).

The Referee concluded that claimant was a subject worker. In doing so, the Referee reasoned that claimant was not an independent contractor under ORS 656.005(29) and 670.600. We agree, based on the following reasoning.

Subsequent to the Referee's order, the Supreme Court in S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994), held that the definition of independent contractors in ORS 670.600, in and of itself, does not specify how it affects workers' compensation coverage for independent contractors. Rather, the first determination to be made in subjectivity cases is whether claimant is a "worker." "The initial determination of whether one is a 'worker' under ORS 656.005(28) (now 29) continues to incorporate the judicially created 'right to control' test." Id. at 630.

The factors to be considered under the "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).

According to the parties' lease agreement, it was Oldham's obligation to repair and maintain the roof of the building. The agreement confirms that Oldham's "roof repair" obligation was completely separate from claimant's responsibility to remodel the interior of the building. Because Oldham was apparently neither personally equipped nor capable of performing the work, it was necessary for her to hire someone to do the work.

Oldham did not exercise control over the particular way the roof was repaired. Nevertheless, because she was the owner of the building and was required to maintain the roof in good repair pursuant to the lease agreement, she had the right to control claimant's work.

Oldham did not actually pay claimant or the other worker the amount they had earned for the work done before claimant fell and was injured. However, at the time the work commenced, it was contemplated that claimant and the other worker would each receive ten dollars per hour from Oldham.

Furthermore, Oldham told an investigator from the Department of Consumer and Business Services (then the Department of Insurance and Finance), that claimant had "submitted a bid to repair the roof." (Ex. 6). Such an admission supports a conclusion that Oldham hired claimant because she did not believe that he was responsible for roof repair under the lease.

Moreover, Oldham supplied the material to seal the skylights. (Tr. 69). Finally, if Oldham had not been satisfied with the way the work was done by claimant and the other worker, claimant testified that she would have had the right to fire them without liability. (Tr. 68). We find this testimony particularly enlightening because claimant was aware that Oldham had fired at least one other worker at the site of the commercial property claimant was leasing. Accordingly, we find that, under all four elements of the "right to control" test, claimant was a "worker" hired by Oldham for remuneration to repair the roof on the leased building. See ORS 656.005(28).

Oldham further argues that claimant was operating as a corporation and was not required to qualify as an independent contractor. Thus, Oldham asserts that claimant was a nonsubject worker under ORS 656.027(9). We disagree.

ORS 656.027(9) states that "corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation" are nonsubject workers. In asserting that claimant is a nonsubject worker because claimant is a corporate officer, Oldham incorrectly interprets ORS 656.027(9). For purposes of his own corporate business (boat building) claimant may not be a subject worker. However, this statute does not apply to claimant in instances when claimant (in his individual capacity) is hired to perform work in a business not related to claimant's corporate business of boat building. See ORS 656.027(9).

Finally, Oldham argues that if claimant is a worker, he is a nonsubject "casual" worker pursuant to ORS 656.027(3). We disagree.

"Casual" refers to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200. ORS 656.027(3)(b). Here, claimant and another worker each worked approximately 15 hours in a two and one-half day period. Had they been paid what they had earned pursuant to the agreement ($10 per hour), Oldham would have paid a total of approximately $300. Thus, the employment was not "casual," as defined by ORS 656.027(3)(b). Furthermore, claimant's employment was in the course of Oldham's business (commercial building leasing). See ORS 656.027(3)(a)(A). Therefore, we conclude that claimant is not a "nonsubject" worker.

Attorney Fee

The Referee did not award an attorney fee to claimant's counsel for services rendered at this "subjectivity" hearing. On review, claimant seeks an attorney fee award.

Subsequent to the Referee's Opinion and Order, we issued Stephen M. Olefson, 46 Van Natta 1762 (1994). In Olefson, we held that claimant's counsel was entitled to an "out-of-compensation" fee for his attorney's successful efforts at a Board hearing in overturning the Department's determination that it was unable to find that claimant was a subject worker. This award would be payable from claimant's temporary disability, if any, arising from the referee's "subjectivity" determination, not to exceed $1,050.

Therefore, following Olefson, claimant's attorney in this case is entitled to an attorney fee paid from claimant's award of future compensation, if any, under ORS 656.386(2) for his counsel's services at the subjectivity hearing. This fee shall equal 25 percent of the increased temporary disability, if any, eventually resulting from this order, not to exceed $1,050. See OAR 438-15-045; Stephen M. Olefson, supra.

Finally, to the extent that claimant's respondent's brief can be interpreted as a request for an attorney fee award under ORS 656.382(2), it is denied. As discussed in the Olefson decision, the Referee's order did not "award" compensation. Rather, it set in motion a process which could eventually result in compensation. Because the statutory prerequisite to an attorney fee award under ORS 656.382(2) has not been satisfied, we are not authorized to grant such an award.

ORDER

The Referee's order dated February 1, 1994 is affirmed in part and reversed in part. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation, if any, resulting from the Referee's order, not to exceed $1,050. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
GINA M. PRICE, Claimant
WCB Case No. 93-15205
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Howell's order which: (1) found that claimant's back claim had not been prematurely closed; and (2) upheld the insurer's "de facto" denial of claimant's aggravation claim for her mid-back condition. On review, the issues are premature closure and aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt and affirm that portion of the Referee's order which set aside the Order on Reconsideration, affirmed the Notice of Closure, and found that the claim had not been prematurely closed.

Aggravation

The Referee found that there was no medical evidence supported by objective findings indicating that claimant's condition had worsened since the last arrangement of compensation. Accordingly, the Referee upheld the insurer's "de facto" denial of claimant's aggravation claim for her compensable thoracolumbar strain condition. We disagree.

In order to establish a compensable aggravation, claimant must prove that her back condition worsened since the last arrangement of compensation. See ORS 656.273(1). In this case, the parties agree that claimant's aggravation claim was filed during the "reconsideration" proceeding. Therefore, consistent with our finding herein that her claim was not prematurely closed, the last arrangement of compensation is the September 1993 Notice of Closure. See Lindon E. Lewis, 46 Van Natta 237 (1994), aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994).

To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. See Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). The worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1). In this case, because claimant did not receive a permanent disability award for her back condition, she need not prove that her worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. See ORS 656.273(8).

When Dr. Kaesche, claimant's treating physician, last examined her in September 1993, he found subjective complaints of pain and tenderness in the mid-thoracic area, compatible with a history of thoracolumbar strain, with the pain essentially unchanged since his previous examination in July 1993. He found no objective findings to substantiate claimant's subjective complaints. He concluded that claimant was medically stationary and able to return to work with no restrictions. (Ex. 7). Previously, he had restricted her work to lifting no more than 40 pounds. (Ex. 4-1). In a subsequent letter, Dr. Kaesche confirmed his opinion that claimant was medically stationary in September 1993, but he gave no opinion regarding claimant's current status, since he had not examined her since September 1993. (Ex. 14).

On November 10, 1993, Dr. Peterson performed a medical arbiter's examination. (Ex. 10). Due to claimant's "great discomfort" in the thoracic region, Dr. Peterson discontinued the examination. (Ex. 10-3). With respect to her accepted thoracolumbar condition, Dr. Peterson found claimant to be acutely uncomfortable on the date of examination, with objective findings of "marked muscle spasm in the neck and shoulder girdle region with trigger points and radiating pain. . . relative both to the shoulder and neck region as well as the thoracic region." (Ex. 10-5). Dr. Peterson found that claimant currently had acute symptoms, resulting from the accepted condition, which prevented her use of the thoracic spine. In addition, she opined that claimant was currently limited to working in a sedentary to light capacity. (Id).

Under these circumstances, comparing Dr. Peterson's examination with Dr. Kaesche's examination shortly before the Notice of Closure, we conclude that claimant has proven, by medical evidence supported by objective findings, that her compensable back condition has worsened such that claimant is less able to work than she was as of the September 1993 Notice of Closure. See Steve A. McCalister, 45 Van Natta 187, 188 (1993). Accordingly, we conclude that claimant proved 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 $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 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 March 21, 1994 is affirmed in part and reversed in part. That portion of the Referee's order which upheld the insurer's "de facto" denial of claimant's November 10, 1993 aggravation claim is reversed. The insurer's "de facto" denial is set aside, and the aggravation claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
PABLO VILLAFUERTE, Claimant
WCB Case No. 93-10195
ORDER ON REVIEW
Schoenfeld, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Referee Schultz's order that set aside its denial of claimant's head and leg injury claim. 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 facts with one change. On page 2, we delete the following sentence: "Employer testified that the edge of the road became, in effect, the parking lot for the workers when the fields were too wet."

CONCLUSIONS OF LAW AND OPINION

On the day of the injury, claimant, a farm laborer, had finished work and had walked across a public road to get into the van to go home. A car turned onto the road and went out of control. Claimant was struck by the car as he was running across the road trying to get away.

SAIF argues that claimant was not injured in the course and scope of employment because the employer did not own or maintain the public road on which claimant was injured, nor did the employer create any special hazard. We agree.

The general rule is that injuries sustained while going to or coming from work are not compensable. One exception is the "parking lot rule," in which injuries sustained on the employer's premises while the employee is proceeding to or from work have a sufficient work-connection to be "in the course of employment." Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366-67 (1994). However, the "parking lot" exception only satisfies the first element of the unitary work-connection analysis. Claimant must also establish that the injury "arose out of" employment; i.e., there must be a sufficient causal 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., whether the employer exercised control over the area where claimant was injured. 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); Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52, 56-58 (1981).

In this case, claimant was injured on a public road. The employer did not own or maintain the road or the land where the vans were parked. Under these circumstances, employer control was not manifested either by employer ownership or maintenance. Nevertheless, we must consider whether the employer exercised control by the presence of employer-created special hazards.

In Adamson v. The Dalles Cherry Growers, Inc., supra, the claimant was injured when she fell on a public street. The employer's facilities were located on both sides of a public street, but the employer had no responsibility for its maintenance. The claimant was forced to park on the street the day of the injury because the other parking areas were unavailable. The street was the only way she could get to work. Nevertheless, the court concluded that the claim was not compensable, reasoning that "there is no evidence that the street had become a part of employer's facilities or that the employer regularly exercised control over street traffic, use of the street or its maintenance." 54 Or App at 59.

In Cope v. West American Ins. Co., supra, 309 Or at 240, the court said:

> "When an employee is injured on a public sidewalk over which the employer has no control, and on which there are no employer-created hazards, the connection between the injury and the employment is insufficient to make the injury compensable. This is so regardless of whether the employee has just come from the employer's parking lot."

In comparison, the Cope court discussed Montgomery v. State Ind. Acc. Com., 224 Or 380 (1960). In that case, the employee was injured when he was struck by a car while crossing a public street as he was leaving work. The employer previously had convinced city authorities to install a traffic control light at the scene of the accident, and the employer controlled the light. The court concluded that, although the injury occurred after work on a public street, the employee was in the course of employment because the injury occurred in an area over which the employer exercised some control.

In Irene F. Shattuck, 45 Van Natta 1752 (1993), the claimant was fatally injured when she was struck by a co-worker's vehicle in the public roadway, as she was crossing the street to the employer's parking lot after work. We concluded that the claim was not compensable. We reasoned that the claimant was not required by the employer to park in that parking lot or in any particular location; the claimant was not required by the employer or by circumstances to cross the street at the particular location she chose; and the employer did not exercise any control over street traffic.

Similarly, in Janet V. Dollens, 42 Van Natta 2004 (1990), aff'd mem, 107 Or App 531 (1991), the claimant fell on a privately-owned walkway. We concluded that the claim was not compensable because the employer had no control over the walkway, its use or maintenance.

We find the present case analogous to Adamson v. The Dalles Cherry Growers, Inc., supra. Here, claimant was injured in the public road. The employer did not own or maintain the road or the land where the vans were parked. Even if we assume that claimant was forced to cross the public road to get back and forth from work, we are not persuaded that the injury occurred in an area over which the employer exercised some control. As in Adamson v. The Dalles Cherry Growers, Inc., supra, the employer here did not exercise any control over street traffic, use of the street or its maintenance. See Irene F. Shattuck, supra; Janet V. Dollens, supra.

We do not find that the employer had the requisite control over the public road where claimant was injured. Consequently, we conclude that claimant has not established that his injury is compensable under the "parking lot" exception to the going and coming rule.

ORDER

The Referee's order dated January 7, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

November 8, 1994 Cite as 46 Van Natta 2337 (1994)

In the Matter of the Compensation of
LEE R. JONES, Claimant
WCB Case No. 92-05254
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

The insurer requests reconsideration of our October 11, 1994 Order on Remand which directed the insurer to continue providing vocational assistance to claimant. Contending that the "suitable employment" issue was "only covered in a very short fashion at hearing," the insurer requests that the Board either abate its order and permit the parties to brief the "suitable employment" issue, or remand this matter to the Hearings Division for further development of the record regarding the "suitable employment" issue. Alternatively, the insurer urges the Board to reverse its holding that claimant was not suitably employed because he was not earning a wage within 20 percent of his last wage. In addition, the insurer requests clarification of a finding of fact.

We begin with the factual question. In the first paragraph of the "Findings of Fact," we referred to claimant's "compensable right and left knee and low back injuries." The insurer correctly notes that it never accepted this condition which was the subject of a January 1993 Disputed Claims Settlement agreement. The factual misstatement had no impact on our reasoning and ultimate holding. However, in the interests of accuracy, we replace the first "Fact" paragraph with the following:

"Claimant, 53 years old at hearing, sustained compensable right and left knee injuries while working for the insured as a journeyman meatcutter in August 1985. At that time, claimant was earning $9.58 an hour."

The insurer contends that the issue of "suitable employment" was not previously addressed by the parties. It requests, therefore, that the Board abate its Order on Remand and permit the parties to brief the "suitable employment" issue, or that the Board remand this matter to the Hearings Division so that the "suitable employment" issue can be fully explored. We deny the insurer's motions.

The Director's conclusion that claimant was not eligible for further vocational assistance was based on his specific finding that "[claimant]'s current employment is suitable." Although much of the parties' focus has been on the scope of review of a Director's order, claimant has consistently maintained that he is entitled to further vocational services because neither the wage nor the physical demands of the janitorial job were "suitable." At hearing, claimant's counsel argued: "We don't feel that [the janitorial job]'s a suitable job, so we don't feel the work [claimant] did was physically suitable nor suitable in terms of a wage[.]" (Tr. 4-5). When the Referee inquired of counsel for the insurer whether he had "any comments" concerning the issues as framed, he responded: "None, Your Honor." (Tr. 5).

Under the circumstances, we conclude that the issue of "suitable employment" was addressed by the parties. Accordingly, we decline the insurer's invitation to abate our order and permit it to brief this issue at this stage in the proceedings.

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).

The insurer has not established that unidentified evidence that it seeks to introduce regarding the "suitable employment" issue was unobtainable with due diligence at the time of hearing. Moreover, we have found that the "suitable employment" issue was raised, developed, and litigated at hearing. The Referee's order addressed claimant's assertions that neither the wage nor the physical demands of the janitorial job were "suitable" in the context of reviewing the Director's order. Therefore, we find the record as presently developed sufficient to conduct our review.

Alternatively, the insurer urges the Board to reverse its holding that claimant was not suitably employed because he was not earning a wage within 20 percent of his last wage. The insurer argues that "according to" the Board's order, a hypothetical worker earning a high wage would not be suitably employed unless earning 20 percent of his last wage, a goal the insurer speculates is impossible within the restrictions of the Workers' Compensation system.

The Board has not set the "20 percent" benchmark. Rather, ORS 656.340(6)(b)(B)(iii) defines "suitable employment" as employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment. Given the fact that the janitor job did not constitute "suitable" employment under the statutory standard, we find no basis to reverse our Order on Remand finding claimant continues to be eligible for vocational assistance.

Accordingly, our October 11, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 11, 1994 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
ANA J. CALLES, Claimant
WCB Case No. 93-12389
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Claimant requests reconsideration of our October 14, 1994 order that affirmed a Referee's order directing the SAIF Corporation to pay claimant's attorneys the fee portion of temporary disability compensation previously paid to claimant. Specifically, claimant objects to that portion of our decision which declined to award a carrier-paid attorney fee under ORS 656.382(2) for her counsel's services on Board review. Having received SAIF's response, we proceed with our reconsideration.

If a request for review is initiated by a carrier, and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the carrier shall be required to pay a reasonable attorney fee. ORS 656.382(2). Since carrier-paid attorney fees are not part of a claimant's compensation, a claimant is not entitled to an additional attorney fee award on Board review for defending a Referee's carrier-paid attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986). However, attorney fees which are payable out of a claimant's compensation retain their identity as "compensation." ORS 656.386(2); Steiner v. E. J. Bartells Co., 114 Or App 22, 25 (1992); SAIF v. Gatti, 72 Or App 106 (1985).

Here, claimant asserts that we erred in declining to award her counsel a "382(2)" attorney fee for successfully defending the Referee's decision which directed SAIF to pay claimant's counsel an "out-of-compensation" attorney fee. Inasmuch as the Referee's attorney fee directive did not constitute a carrier-paid award, claimant reasons that our reliance on the Dotson holding was misplaced.

SAIF responds that claimant is not entitled to a "382(2)" attorney fee award. Reasoning that the dispute in this case pertained to whether it was required to pay an additional amount to claimant's attorney above the temporary disability already paid to claimant, SAIF contends that it did not seek the "disallowance" or "reduction" of claimant's compensation.

After further consideration, we conclude that the Dotson holding has no bearing on this case. In light of Steiner and Gatti, it is apparent that the Referee's "out-of-compensation" attorney fee award constituted "compensation." The identity of this award as "compensation" is further confirmed by the Referee's authorization to SAIF to recover this overpayment from claimant's future awards of permanent disability compensation.

SAIF also misinterprets the requirements for a carrier-paid attorney fee award under ORS 656.382(2). The statute does not require that the appealing carrier "seek" disallowance or reduction of a claimant's compensation award. Rather, the necessary prerequisite for a "382(2)" award is that the Board "finds" that the compensation award not be disallowed or reduced. Inasmuch as we affirmed the Referee's "out-of-compensation" attorney fee directive and future offset authorization, it necessarily follows that we found that claimant's compensation award should not be disallowed or reduced. Consequently, we hold that claimant's counsel is entitled to an attorney fee award under ORS 656.382(2) for her counsel's services on Board review and 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 before the Board is $600, payable 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), the complexity of the issues, and the value of the interest involved.

Accordingly, we withdraw our October 14, 1994 order. On reconsideration, as supplemented and modified herein, we republish our October 14, 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
BRENDA G. CHANEY, Claimant
WCB Case Nos. 93-10941 & 93-12355
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of those portions of Referee Hazelett's order which: (1) affirmed an Order on Reconsideration setting aside a Notice of Closure as premature; and (2) assessed a penalty and attorney fee for the employer's allegedly unreasonable claim processing in prematurely issuing the Notice of Closure. Claimant cross-requests review of that portion of the Referee's order which affirmed a Director's order denying reimbursement for future medical services. On review, the issues are premature closure, medical services 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

Premature Closure and Penalties

After our review of the record, we adopt the Referee's reasoning concerning the premature closure issue, as well as the conclusion that a penalty is warranted. However, we modify the penalty assessment.

Claimant is entitled to a penalty under ORS 656.268(4)(f) for the employer's unreasonable issuance of a Notice of Closure without authorization to do so under ORS 656.268(4)(a). The Referee assessed a penalty payable one-half to claimant and one-half to her attorney. (See Opinion and Order at 5, 7). However, ORS 656.268(4)(f) provides that a penalty assessed under that statute shall be paid entirely to the worker. Therefore, we modify the Referee's order accordingly, directing the employer to pay the entire penalty to claimant.

Inasmuch as claimant did not timely submit her appellate brief, no attorney fee pursuant to ORS 656.382(2) shall be awarded for services on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

Medical Services

First, we briefly summarize the pertinent facts. Claimant sustained a compensable injury in 1987. In May and June 1992, her treating physician, Dr. Aversano, requested authorization for a weight loss program and a back rehabilitation program. In June 1993, the Director initiated review of the proposed medical services under ORS 656.327.

In an order issued August 11, 1993, the Director determined that the proposed medical services were not appropriate and the self-insured employer was not required to reimburse claimant for those services, if rendered. (Ex. 131). Claimant requested a hearing.

The Referee issued an order affirming the Director's order. Pursuant to his review authority under ORS 656.327, the Referee found that the Director's order was supported by substantial evidence in the whole record. Alternatively, on de novo review, the Referee determined that the proposed medical services were not compensable because they were not reasonable and necessary.

Claimant filed a cross-request for review on the medical services issue. Since her brief was not timely filed, it has not been considered. Nevertheless, because her request for review was timely, we have proceeded with our review of the issue.

Because the Director does not have jurisdiction over the appropriateness of proposed medical services under ORS 656.327, see Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), we have remanded such cases to the Hearings Division for a de novo hearing. See Jeanette E. Bollingberg, 45 Van Natta 2439 (1993); Lynda M. England, 45 Van Natta 2191, on recon 45 Van Natta 2402 (1993).

Here, inasmuch as the Referee conducted a hearing and made a de novo determination, remand is unnecessary. After our review of the record, we agree with the Referee's determination that the proposed medical services are not reasonable and necessary treatment for this claimant's compensable condition. Accordingly, we adopt and affirm that portion of the Referee's order which determined de novo that the self-insured employer is not required to reimburse claimant for the proposed weight loss and back rehabilitation programs.

Because the Director lacked jurisdiction of this dispute over proposed medical treatment, the Director's order has no effect. Therefore, we modify the Referee's order. In lieu of that portion of the Referee's order which affirmed the Director's August 11, 1993 order, we hold that the proposed medical services are not reasonable and necessary. Therefore, we uphold the self-insured employer's "de facto" denial of medical services for formal weight loss and back rehabilitation programs.

ORDER

The Referee's order dated February 7, 1994 is affirmed in part and modified in part. In lieu of that portion of the Referee's order which assessed a penalty, payable one-half to claimant and one-half to her attorney, the self-insured employer shall pay to claimant a penalty equal to 25 percent of all compensation then due, pursuant to ORS 656.268(4)(f). In lieu of that portion of the Referee's order which affirmed the Director's August 11, 1993 order, the self-insured employer's "de facto" denial of medical services is upheld. The remainder of the Referee's order is affirmed.

November 9, 1994 Cite as 46 Van Natta 2341 (1994)

In the Matter of the Compensation of
JERALD FATTIG, Claimant
Own Motion No. 94-0108M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

On March 30, 1994, the Board authorized the reopening of claimant's left elbow injury claim for the payment of temporary disability compensation beginning the date claimant is hospitalized for the proposed knee surgery. By letter dated September 14, 1994, the SAIF Corporation notified the Board that claimant has decided not to proceed with the proposed surgery at this time. SAIF submits a form signed by claimant that confirms SAIF's representations. As a result of claimant's decision to forego the proposed surgery, SAIF requests that we "rescind" our prior order. We treat this request as a request for reconsideration of our March 30, 1994 Own Motion Order. For the following reasons, we deny that request.

Pursuant to OAR 438-12-065(2), SAIF had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if SAIF could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. OAR 438-12-065(2).

We acknowledge that, in the past, we have found that extraordinary circumstances exist justifying reconsideration of an order that authorized the reopening of an own motion claim based on a proposed surgery where the proposed surgery was not performed. See, e.g., Terry L Cleland, 45 Van Natta 2197 (1993) (the claimant cancelled the proposed surgery for "personal family reasons"); Brian A. Chambers, 45 Van Natta 2021 (1991) (the claimant's physician subsequently opined that, although the claimant would require the proposed surgery at some point in the future, he was currently functioning well without it). In such cases, we withdrew and reconsidered our prior orders. Reasoning that the

claimants had failed to establish that they required surgery or hospitalization now or in the near future, we concluded that we were without authority under ORS 656.278(1)(a) to grant the requests to reopen the claims. Therefore, we denied the requests for own motion relief, noting that, should the compensable conditions require surgery or hospitalization in the future, the claimants could again request own motion relief at that time. Id.

After further consideration, we find that a claimant's failure to undergo a proposed surgery or other treatment requiring hospitalization does not constitute extraordinary circumstances that would justify reconsideration of an order outside of the deadlines imposed by OAR 438-12-065(2). We base that finding on the following reasoning.

ORS 656.278(1) gives the Board authority to authorize the reopening of a claim for which aggravation rights have expired. However, that authority is limited. Additional monetary benefits are limited by ORS 656.278(1)(a), which provides that, where a compensable injury worsens requiring surgery or hospitalization, "the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery[.]" (Emphasis added). Thus, by statute, a worker is not entitled to temporary disability compensation until his or her compensable condition has worsened requiring surgery or hospitalization and he or she actually undergoes the surgery or hospitalization.

Therefore, own motion orders that authorize the reopening of a claim based on a compensable worsening that requires a surgery or hospitalization that has not yet been performed are essentially "contingent" orders. Since surgery or hospitalization is a prerequisite for authorization for reopening, it follows that an own motion order may not authorize the payment of temporary disability benefits until that surgery or hospitalization occurs. ORS 656.278(1)(a). If surgery or hospitalization subsequently occurs, then the prerequisite would be met and there would be no need to issue a further order. On the other hand, if surgery or hospitalization does not occur, then the claim would not be reopened under the own motion order as the necessary prerequisite would not have occurred.

Here, the prerequisite has not occurred in that claimant has not undergone the proposed surgery. Therefore, the March 30, 1994 order remains a "contingent" order, since the necessary prerequisite for reopening the claim for own motion relief has not yet occurred. Because the order remains contingent, there are no extraordinary circumstances that would justify reconsideration. Finally, to the extent that any prior orders allowed reconsideration based on extraordinary circumstances and reversed essentially contingent own motion orders based on the fact that the proposed surgery or hospitalization had not yet occurred, we disavow those orders.

Accordingly, SAIF's request for reconsideration of the Board's March 30, 1994 order is denied.

IT IS SO ORDERED.

November 9, 1994 Cite as 46 Van Natta 2342 (1994)

In the Matter of the Compensation of
DORIS L. LOEHR, Claimant
WCB Case No. 94-02398
ORDER ON REVIEW
Moscato, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant, pro se, requests review of Referee Hoguet's order that dismissed her hearing request as having been abandoned. On review, the issue is dismissal.

The Board adopts and affirms the Referee's order with the following supplementation.

Claimant alleges that her failure to appear at the May 12, 1994 hearing in this matter was caused by confusion resulting from an April 1, 1994 letter she received from the Bureau of Labor and Industries

(BOLI). The letter informed her that her "complaint filed with the Civil Rights Division has been closed." Based on that letter and a subsequent conversation she had with a BOLI representative, she assumed there would no longer be a hearing on her workers' compensation claim.

Even assuming that claimant's representations are true, we do not find extraordinary circumstances justifying claimant's failure to appear at hearing. See OAR 438-06-071(2). Claimant herself filed the civil rights complaint and the hearing request on her workers' compensation claim. BOLI's April 1, 1994 letter expressly addressed claimant's civil rights complaint and, at the time she received that letter, she had already received notice of the scheduled hearing on her workers' compensation claim. There was no reasonable basis for confusing her civil rights complaint with her workers' compensation claim. Accordingly, claimant's hearing request was properly dismissed.

ORDER

The Referee's order dated May 16, 1994 is affirmed.

In the Matter of the Compensation of
BETTY J. LOWE-HARPOLE, Claimant
WCB Case No. 93-01520
ORDER ON RECONSIDERATION
Dobbins, et al., Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 11, 1994 Order on Review that reversed a Referee's order that had upheld its denial of claimant's aggravation claim for a cervical condition. On reconsideration, SAIF asks us to reexamine the medical evidence and conclude that claimant has failed to establish that her current cervical condition was a compensable aggravation of her accepted cervical strain.

We withdraw our October 11, 1994 order for reconsideration, and offer the following response to SAIF's arguments.

SAIF asserts that we erred in finding that, in his final report, Dr. Freemen "specifically declined to concur with Dr. Logan's opinion that claimant's 1991 off-work accident was the major contributing cause of her current cervical condition." (Order on Review at 2). We disagree. In the report, a "check-the-box" concurrence letter drafted by SAIF's counsel, Dr. Freeman checked the "No, I do not concur" box. (Ex. 40a). He then offered a hand-written explanation regarding his disagreement with part of the second page of Dr. Logan's report.

We do not interpret Dr. Freeman's "check-the-box" report as only declining to concur with the second page of Dr. Logan's report. Instead, we conclude that, by checking the "No, I do not concur" box, Freeman disagreed generally with Logan's report, and that Freeman's hand-written notation merely reflected his particular disagreement with part of the second page of that report. Accordingly, we reject SAIF's argument to the contrary.

The remainder of SAIF's request for reconsideration focuses on whether claimant has established that her current cervical condition is a compensable aggravation. On review, the only issue in dispute was whether SAIF had met its burden of establishing that the major contributing cause of claimant's alleged aggravation was the 1991 off-work accident. Fernandez v. M & M Reforestation, 124 Or App 38 (1993); see ORS 656.273(1). As we stated in our prior order, on review, the parties did not contest that claimant's accepted cervical strain was a material contributing cause of her current cervical condition. (Order on Review at 1).

Now, on reconsideration, SAIF seeks to revisit the issue of whether claimant has met her initial burden of proving the compensability of her current cervical condition as an aggravation. We are not inclined to address that issue, because it was not contested on review. See Mark S. Lillibridge, 46 Van

Natta 776 (1994) (on reconsideration, Board declined to address issue not raised at hearing or on review); see also Kenneth D. Nichols, 45 Van Natta 1729 (1993) (Board generally will not consider a new theory raised for first time on reconsideration). However, were we to consider that issue, we would nevertheless find that claimant has met her burden of proof. (Exs. 21, 42).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 11, 1994 order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 10, 1994 Cite as 46 Van Natta 2344 (1994)

In the Matter of the Compensation of
DARREYL DAVIS, Claimant
Own Motion No. 93-0366M
OWN MOTION ORDER ON RECONSIDERATION
Gloria Schmidt, Claimant Attorney
Liberty NW Insurance Corporation, Insurance Carrier

On July 8, 1993, the insurer recommended against reopening claimant's 1986 low back injury claim based on its contention that claimant did not require surgery or hospitalization. Claimant's aggravation rights expired on May 24, 1993. However, there was a possibility that claimant had perfected an aggravation claim before his aggravation rights expired. Such a circumstance would take the matter out of the Board's own motion jurisdiction.

To resolve this jurisdictional question, on July 28, 1993, the Board issued on Own Motion Order referring the matter for consolidated hearing with WCB Case No. 93-06529, then pending in the Hearings Division before Referee McWilliams. In part, we requested Referee McWilliams to take evidence on whether claimant had filed a timely aggravation claim and to make a recommendation in regard to the aggravation issue.

On September 30, 1993, Referee McWilliams issued an order in which she determined that claimant had filed a timely aggravation claim via his attorney's "Petition to Reopen," which was received by the insurer on May 24, 1993.[1] The insurer did not issue a denial of the aggravation claim and had 90 days within which to process the claim before it became "de facto" denied. Referee McWilliams found that the Hearings Division did not have jurisdiction to adjudicate the compensability of the aggravation claim because claimant's hearing request was premature, in that he had requested a hearing before the expiration of the 90 day processing period. Assuming arguendo that the Hearings Division had jurisdiction, Referee McWilliams concluded that claimant had failed to prove a compensable aggravation.

On December 1, 1993, we issued an Own Motion Order in which we denied claimant's request for own motion relief. We based our conclusion on the reasoning that, because Referee McWilliams' order established that claimant had not proven a compensable aggravation claim pursuant to ORS 656.273 and his aggravation rights had expired, claimant's claim was within the Board's own motion jurisdiction. However, because there was no evidence that claimant's condition had worsened requiring surgery or hospitalization, we concluded that we were without authority to reopen the claim. ORS 656.278(1)(a).

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[1] We note that Referee McWilliams identified December 1, 1988 as the date of injury in the heading portion of her September 30, 1993 order. However, the claim number (C604131992) identified in the heading portion of the order is the same claim number as that of the November 13, 1986 injury that is the subject of the current own motion matter. Furthermore, there is no indication of an accepted December 1, 1988 injury in the body of the Referee's order or in the own motion record. All references to the compensable injury in the body of the Referee's order relate to the November 13, 1986 injury. For these reasons, we assume that the date of injury listed in the heading portion of the September 30, 1993 order is a typographical error and that the date of injury should be listed as November 13, 1986.

On December 15, 1993, claimant requested reconsideration of our December 1, 1993 order, noting that Referee McWilliams had abated her order and was reconsidering the order. On December 30, 1993, we abated our December 1, 1993 order.

On June 7, 1994, Referee McWilliams issued an Order on Reconsideration in which she adhered to her original decision. Claimant requested review of that order; however, he subsequently withdrew his request for review. Consequently, on August 30, 1994, the Board issued an order dismissing claimant's request for review.

Accordingly, Referee McWilliams' September 30, 1993 order has become final by operation of law, and we proceed with our reconsideration.[2]

The Board's own motion authority extends only to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Here, it has been determined that claimant filed a timely aggravation claim. That fact takes this claim out of the Board's own motion jurisdiction.

We note that the compensability of that aggravation claim has not yet been determined. Referee McWilliams concluded that the Hearings Division was without jurisdiction to decide the compensability issue because the request for hearing was premature. That conclusion has become final by operation of law. Her discussion regarding the compensability of the aggravation claim "assuming arguendo" that the Hearings Division had jurisdiction is dicta.

As far as we are able to determine, the aggravation claim perfected on May 24, 1993 remains in "de facto" denied status. The Board has determined that there is no time limit for the filing of a request for hearing to contest a "de facto" denial. Frances I. Clinton, 44 Van Natta 1763 (1992); John R. Watts, 41 Van Natta 2122 (1989); Roger G. Prusak, 40 Van Natta 2037, 2040 (1988). Therefore, the compensability of claimant's May 24, 1993 aggravation claim remains viable.

In any event, because we lack own motion jurisdiction to consider claimant's claim, claimant's request for own motion relief is dismissed.

IT IS SO ORDERED.

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[2] We are aware that a hearing is awaiting docket assignment regarding the November 13, 1985 injury claim that is the subject of the current own motion matter. (WCB Case No. 93-13709, Case No. C604131992). However, the issues raised in that pending hearing involve penalties and attorney fees. Because those issues do not affect the current own motion matter, there is no need to continue abating the own motion matter pending resolution of that dispute.

In the Matter of the Compensation of
LARRY W. GANGE, Claimant
WCB Case Nos. 90-21432 & 90-15533
THIRD ORDER ON RECONSIDERATION
Estell & Bewley, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys

EBI Companies requests reconsideration of our October 24, 1994 Second Order on Reconsideration. EBI seeks clarification of that portion of our decision which affirmed the Referee's conclusion that claimant's EBI claim had been prematurely closed. Specifically, EBI asks that we identify which claim closure we found to be premature. In response, claimant contends that our decision "rendered void" a "second Notice of Closure" issued subsequent to the Referee's order in this case.[1]

The scope of our review is limited to the issues presented at the April 5, 1991 hearing. As noted in the Referee's July 29, 1991 order, the premature closure issue pertained to the July 16, 1990 Determination Order. Since any "post-hearing" closure decisions could not have been issues raised at the hearing, it likewise follows that we are without appellate review authority to consider such matters. Thus, our premature closure conclusion solely pertains to the July 16, 1990 Determination Order, the only claim closure decision raised at the April 5, 1991 hearing.

In conclusion, we continue to acknowledge that our decision may have significant ramifications on future claim processing decisions regarding claimant's EBI claim. (Particularly since a "post-hearing" closure notice was apparently not appealed within 180 days of its issuance.) Nevertheless, any future disputes regarding the processing of the claim are not subject to our appellate review authority in this case.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our prior orders. 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 contends that EBI has "waived" its right to contest our October 24, 1994 order because it "did not within the time allowed, request reconsideration of the first order." To begin, our first reconsideration order (October 14, 1994) was issued in direct response to EBI's Motion for Reconsideration. Consequently, we disagree with the factual premise of claimant's contention. In any event, since EBI has timely requested reconsideration of our October 24, 1994 Second Order on Reconsideration and because that order withdrew and then republished (as supplemented) all prior orders, we are authorized to grant its request for further clarification.

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
THIRD ORDER ON REMAND
Craine & Love, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

In our October 28, 1994 Second Order on Remand we increased claimant's scheduled permanent disability award for loss of use or function of her right forearm from 34 percent (51 degrees), as granted by the Referee's order, to 52 percent (78 degrees). In addition to approving an "out-of-compensation" attorney fee, we awarded a $4,000 insurer-paid attorney fee under ORS 656.388(1) for claimant finally prevailing after remand regarding her permanent disability claim.

The insurer has moved for reconsideration. Asserting that claimant's attorney fee award must be limited to a share of the increased compensation, the insurer contends that we are without authority to award an insurer-paid attorney fee. We disagree.

In essence, the insurer challenges the rationale contained in Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). In Beswick, we awarded a claimant a carrier-paid attorney fee for finally prevailing after remand from a carrier's appeal of a Board order which had affirmed a referee's permanent total disability award. Reasoning that the claimant had finally prevailed after remand "in respect to any claim or award for compensation," we held that the claimant was entitled to a carrier-paid attorney fee pursuant to ORS 656.388(1).

The insurer contends that ORS 656.388 does not provide a separate basis for a carrier-paid attorney fee award in addition to ORS 656.382 and 656.386. Consequently, the insurer asserts that the basis for our carrier-paid attorney fee award in Beswick was actually ORS 656.382(2). Since our remand order in this case issued in response to claimant's petition for judicial review, the insurer reasons that claimant's attorney fee is limited to the "out-of-compensation" fee awarded under ORS 656.386(2).

The insurer provides no case authority for its argument that the Beswick reasoning was contrary to the statutory scheme. To the contrary, there is recent case precedent which applies the Beswick rationale to situations analagous to the present case. In Tamara J. Sigler, 46 Van Natta 1931 (1994), and Valorie L. Leslie, 46 Van Natta 1919 (1994), carrier-paid attorney fees under ORS 656.388(1) were awarded in addition to an "out-of-compensation" attorney fee when the claimants finally prevailed after remand following their appeals regarding the Board's prior refusals to increase their permanent disability awards. Both decisions cited ORS 656.388(1) and Beswick.

In light of such circumstances, we adhere to the principle expressed in Beswick that, when a claimant finally prevails after remand to the Board in respect to any claim or award for compensation, ORS 656.388(1) authorizes a carrier-paid attorney fee. Here, since claimant finally prevailed after remand with respect to her claim for an increased permanent disability award, we continue to conclude that her attorney is entitled to a carrier-paid fee pursuant to ORS 656.388(1).

Accordingly, we withdraw our October 28, 1994 order. On reconsideration, as supplemented herein, we republish our October 28, 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
HAROLD W. WEBER, Claimant
WCB Case No. C4-02487
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Roger D. Wallingford, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Member Neidig and Gunn.

On October 4, 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 October 11, 1994, the Board requested that the parties submit an addendum to the CDA bringing the attorney fee into compliance with OAR 438-15-052, or providing an explanation of extraordinary circumstances sufficient to justify a larger attorney fee. Specifically, the original proposed agreement provided for payments to claimant of $800 per month for 120 months. The present value of the annuity is $72,000. See OAR 438-15-052(2). The agreement also provided for a $10,500 attorney fee for claimant's counsel.

The parties' addendum states that the attorney fee has been negotiated directly with the insurer for claimant's counsel's services "over and above" compensation. The parties contend that the fee is to be paid "in addition to compensation."

Regardless of the manner in which the attorney fee is characterized, however, we have previously held that entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. Roger B. Lindsay, 43 Van Natta 1645 recon den 43 Van Natta 1863 (1991). Furthermore, where the agreement provides for a structured settlement with proceeds to be paid over an extended period of time while the attorney fee is to be paid when the CDA is approved, we require the present discounted value of the settlement to determine whether the proposed attorney fee is within the strictures of OAR 438-15-052. If the attorney fee exceeds that amount and the agreement does not indicate any extraordinary circumstances in support of the proposed fee, we have found the proposed disposition to be unreasonable as a matter of law. Lindsay, supra; Thomas M. Green, 43 Van Natta 1517 (1991).

Here, because the agreement provides for the proceeds to be paid in more than one payment payable within a period of more than one year from the date of approval, the attorney fee is calculated based on the present value of the annuity. See OAR 438-15-052(2). The parties have stipulated that the present value of the settlement is $72,000. Thus, in accordance with the aforementioned rule and absent extraordinary circumstances, claimant's attorney fee cannot exceed $9,075 (25 percent of the first $12,500 ($3,125) and 10 percent of the remaining $59,500 ($5,950). Yet, the agreement effectively provides for a total attorney fee of $10,500.

The parties, through their respective legal representatives, have alternatively provided that, to the extent it is necessary to stipulate and agree that the attorney fee is extraordinary, they agree that an extraordinary fee is justified because the case required an extraordinary amount of professional time, research, and expertise. Based on those representations and in the absence of any objections, we find that extraordinary circumstances justify the proposed attorney fee award. However, if such an objection is made, it must be filed within 10 days of the date of mailing of this order. OAR 438-09-035(1).

We conclude that the agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 438-15-052(1). Moreover, after considering the parties' express agreement regarding claimant's attorney's efforts, as well as the complexity of this case, we find that extraordinary circumstances exist to justify the proposed attorney fee of $10,500. See OAR 438-15-052(1). An extraordinary attorney fee of $10,500, payable to claimant's counsel, is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN K. MARLNEE, Claimant
WCB Case No. 93-12153
ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Pursuant to our October 14, 1994 Order on Reconsideration, we republished our September 20, 1994 Order on Review that: (1) reduced claimant's scheduled permanent disability award for loss of use or function of the left forearm (wrist) from 28 percent (42 degrees), as awarded by a Referee's order, to 24 percent (36 degrees) (the award previously granted an Order on Reconsideration; (2) affirmed the Referee's attorney fee award under ORS 656.382(2); and affirmed the Referee's penalty assessment under ORS 656.268(4)(g).

Noting that the parties have reached a settlement of their dispute, the self-insured employer seeks abatement of our order so that we can retain jurisdiction to consider their agreement. Based on the employer's unrebutted representation, we withdraw our prior orders. On receipt of the parties' executed stipulation, we shall proceed with our review of their agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA K. PERINI, Claimant
WCB Case No. C4-02558
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On October 10, 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 October 17, 1994, we requested that the parties submit an addendum to the CDA clarifying claimant's accepted condition. Specifically, the CDA stated that claimant's accepted condition is "Sleep/wake schedule disorder, resolved."

We have previously disapproved proposed agreements that contain language that could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245. See Monty L. Lewis, 45 Van Natta 2327 (1993); Marilyn London, 43 Van Natta 1689 (1991). Here, we find that use of the word "resolved" in describing an accepted condition in a CDA could be interpreted to limit future medical services.

On October 31, 1994, we received the parties' addendum. The addendum states that, although the accepted condition is "sleep/wake schedule disorder, resolved," the parties understand and agree that the word "resolved" should not be interpreted to provide that there is no remaining compensable condition for which claimant may seek medical treatment in the future. The addendum further states that claimant retains any right to medical services given under ORS 656.245.

Accordingly, because the parties' addendum expressly provides that the term "resolved" shall not limit any compensable medical services to which claimant may be entitled, we find that the parties' CDA, as amended, is not unreasonable as a matter of law. We conclude that the amended agreement is in accordance with the terms and conditions prescribed by the Director. Accordingly, the CDA is approved. See ORS 656.236(1); OAR 438-15-052(1). An attorney fee of $2,625, payable to claimant's counsel, is approved.

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

IT IS SO ORDERED.

November 14, 1994 Cite as 46 Van Natta 2350 (1994)

In the Matter of the Compensation of
KEITH C. BROWN, Claimant
WCB Case No. 93-07911
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Garaventa's order that dismissed his request for hearing on timeliness grounds. On review, the issue is timeliness of the hearing request.

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

Claimant argues that his request for hearing was timely filed, because it was mailed to the employer's claims processor within 60 days of notification of the denial. However, ORS 656.283(3), OAR 438-05-046(1)(a)&(b), and the notice of appeal rights on the denial clearly provide that filing is accomplished at the Board. Thus, even though claimant mailed his request for hearing within the time limitation, he did not "file" it when he mailed the request for hearing to the wrong entity.

ORDER

The Referee's order dated March 9, 1994 is affirmed.

November 14, 1994 Cite as 46 Van Natta 2350 (1994)

In the Matter of the Compensation of
MAURICIO ESTRADA-PACHECO, Claimant
WCB Case No. 93-10456
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Brown's order that: (1) decreased claimant's unscheduled permanent disability award for a right shoulder injury from 55 percent (176 degrees) to 19 percent (60.8 degrees); and (2) decreased claimant's scheduled permanent disability award for loss of use or function of the right arm from 5 percent (9.6 degrees) to zero. On review, the issues are extent of unscheduled and scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable injury involving his right shoulder on August 1, 1992. A Notice of Closure issued April 19, 1993, which awarded claimant 19 percent unscheduled permanent disability. Pursuant to an August 4, 1993 Order on Reconsideration, claimant's award of unscheduled permanent disability was increased to 55 percent. Claimant was also awarded 5 percent scheduled permanent disability for a chronic condition limiting the repetitive use of his right arm. The self-insured employer requested a hearing.

The Referee determined that the impairment findings of claimant's treating physician, Dr. Gilsdorf (orthopedic surgeon), were more reliable than the findings of the medical arbiter, Dr. Fitzsimmons (orthopedic surgeon). Therefore, the Referee modified the Order on Reconsideration to award 19 percent unscheduled permanent disability, with no award of scheduled permanent disability.

Extent of Unscheduled Permanent Disability

We first note that, instead of the rules referenced by the Referee, the applicable administrative rules are contained in WCD Admin. Order 6-1992.

Claimant argues that his adaptability factor should be calculated as "3," rather than "2," as found by the Referee. Specifically, claimant asserts that his treating physician's restriction against overhead reaching entitles him to a residual function capacity (RFC) classification of "light." See OAR 436-35-270(3)(e), (g); 436-35-310. We disagree.

OAR 436-35-310(4) provides:

> "For those workers determined by these rules to have a RFC established between the two categories and also have restrictions, the next lower classification shall be used."

However, the relevant portion of OAR 436-35-270(3)(e) defines "restrictions" as:

> "A worker is also considered to be restricted if permanently precluded from frequently performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling." (Emphasis supplied).

Claimant's argument that his RFC is properly calculated at the next lower strength classification is based upon a reaching restriction imposed by his treating physician. However, claimant has the burden of showing that he is permanently precluded from "at least two" of the aforementioned activities. OAR 436-35-270(3)(e). Inasmuch as claimant has only proven one restriction (overhead reaching), his RFC is correctly determined to be "medium/light," thereby resulting in an adaptability factor of "2." OAR 436-35-310(3).

Extent of Scheduled Permanent Disability

An August 4, 1993 Order on Reconsideration awarded claimant 5 percent for a chronic condition restricting him from the repetitive use of his right arm. (Ex. 28); see OAR 436-35-010(6). However, the Referee found that claimant is not entitled to an award for a chronic condition. The Referee reasoned that the medical arbiter, Dr. Fitzsimmons, was not persuasive. We disagree.

Dr. Fitzsimmons opined that claimant has a "chronic and permanent medical condition" that restricts his ability to work with his right hand above his waist. (Ex. 26-3). Dr. Fitzsimmons later explained that claimant's "chronic condition is most probably a recurrence of the rotator cuff tear, which limits the use of the right arm." (Ex. 27). Furthermore, claimant's treating physician, Dr. Gilsdorf, found claimant's right arm to be medically stationary as of April 1, 1993, with the following restriction: "[Claimant] will be permanently limited in his physical capacities, not able to work in the overhead reaching position with his right upper extremity." (Ex. 22-2).

Medical opinions need not mimic statutory language or use "magic words." See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). It is sufficient that the medical evidence can be reasonably interpreted as establishing that claimant has a chronic condition limiting the repetitive use of a body part. Based on this record, we find that the medical evidence satisfies claimant's burden of proof. Accordingly, we reinstate the Order on Reconsideration award of 5 percent scheduled permanent disability for a chronic condition limiting the repetitive use of claimant's right arm. OAR 436-35-010(6).

Because we have reinstated the scheduled award made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation, not to exceed $3,800. See ORS 656.382(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated December 23, 1993 is affirmed in part and reversed in part. The Order on Reconsideration award of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm 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 (5 percent scheduled permanent disability), not to exceed $3,800. In the event that this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed by Jane A. Volk, supra. The remainder of the Referee's order is affirmed.

November 14, 1994 Cite as 46 Van Natta 2352 (1994)

In the Matter of the Compensation of
VIRGINIA J. HILL, Claimant
WCB Case No. 93-12441
ORDER ON REVIEW
Bryant, Emerson, et al., Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial of her low back injury claim. On review, the issue is compensability.

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

Claimant worked as a resident manager of the employer's mobile home and recreational vehicle park. She sustained an injury in February 1993 when she drove a tenant of the employer's park to the hospital for an appointment. Claimant contends that she was injured in the course and scope of her employment. The Referee found that claimant's testimony concerning her duties as a resident manager was not credible on the basis of her demeanor, inconsistencies in her testimony, admitted misrepresentation in order to obtain benefits from a public agency and noncredible testimony in a hearing in which she attempted to obtain benefits from another public agency. (O & O p.2). The Referee concluded that claimant failed to prove that her injury arose out of and in the course of her employment.

Claimant argues that the Referee erred in relying on another hearing officer's determination that claimant was not credible when she was attempting to obtain benefits from a public agency. Claimant also contends that the Referee erred in "not completely striking statements" made by claimant regarding any admissions she may have made to an investigator from another agency.

We need not decide whether the Referee erred in considering this evidence because excluding the evidence does not change our ultimate disposition of this case. In particular, in our assessment of claimant's credibility, we do not rely on either claimant's admitted misrepresentation in order to obtain benefits from a public agency or another hearing officer's determination that claimant was not credible when she was attempting to obtain benefits from another public agency.

Claimant contends that the Referee erred in finding that she had inconsistent testimony. We disagree. Claimant testified that taking tenants on errands was part of her job duties and that she had never been told otherwise by the employer. On the other hand, the employer testified that she specifically told claimant on three occasions before her injury that she was not to take tenants on errands. In addition, a SAIF claims adjuster testified that she had discussed claimant's job duties with her and had asked claimant if it was part of her job duties to give rides to tenants. According to the claims adjuster, claimant indicated that it was not part of her job duties. (Tr. 69). After reviewing the record, we conclude that the inconsistencies in claimant's testimony were material.

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 adverse credibility finding is based in part upon the observation of claimant's 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). However, our agreement with the Referee's adverse credibility finding is based primarily on claimant's inconsistent testimony.

We agree with the Referee's conclusion that claimant acted outside the course and scope of her employment when she was injured. See Davis v. R & R Truck Brokers, 112 Or App 485 (1992);, Brian W. Andrews, 46 Van Natta 1622 (1994).

ORDER

The Referee's order dated January 31, 1994 is affirmed.

November 14, 1994 Cite as 46 Van Natta 2353 (1994)

In the Matter of the Compensation of
DARLENE H. MERTES, Claimant
WCB Case No. 93-15104
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Neal's order that upheld the SAIF Corporation's denial of claimant's claim for right cervicothoracic, right lumbosacral, right shoulder girdle, and right upper extremity conditions. On review, the issue is compensability.

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

We replace the second sentence of the fourth paragraph of the findings of fact with the following sentence. Dr. Noall noted degenerative changes in the metacarpal joint but assessed "[s]ymptoms consistent with overuse tendinitis of the right upper extremity[.]" (Ex. 26-2).

Claimant compensably injured her right wrist on May 18, 1993. SAIF accepted the claim as a "right wrist strain/tendonitis specific to [the] exposure of 5/18/93." (Ex. 38-1). Based on claimant's contentions at hearing, the Referee analyzed claimant's current shoulder, back, and right upper extremity claim as both an occupational disease and a consequential condition. On review, SAIF contends that claimant did not raise the issue of an occupational disease theory. Contingent upon not being barred from future litigation of her current conditions under an occupational disease theory, claimant concedes that SAIF is correct. We find that claimant raised an occupational disease theory at hearing and that theory was properly considered by the Referee.

In her request for hearing, claimant raised the issues of aggravation and compensability, identifying SAIF's December 16, 1993 denial. Two issues were identified at hearing: (1) compensability of the aggravation claim; and (2) compensability of the cervical, thoracic, lumbar, right shoulder, and right upper extremity conditions. (Tr. 2-3). In explaining the latter compensability issue, claimant's attorney stated that the compensability of those listed conditions was "separately [sic] of [sic] the wrist -- of [sic] the wrist and thumb." (Tr. 3). Thus, claimant did not solely rely on a consequential condition theory of compensability, since such a theory would not be "separate from" the accepted wrist condition.

Furthermore, in his opening statement, the claimant's attorney explained that it would be up to the Referee to decide whether or not claimant's "work activities" make the claim compensable. (Tr. 4). In response to this statement, SAIF's attorney attempted to "clarify" the matter by stating that "the issue is the appeal from the [aggravation] denial and the partial denial related to the claim that's been accepted by SAIF." (Tr. 4). Claimant neither agreed to nor disputed this statement. On this record, we find that claimant raised an occupational disease theory of compensability at least by the time of his opening statement.

OAR 438-06-031 allows for the raising of issues throughout the course of a hearing, provided that the evidence supports the issue not previously raised. The referee may also continue the hearing upon motion of the other party if that party is surprised and prejudiced by the additional issue. Id. Whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the referee's discretion. Susan D. Troxell, 42 Van Natta 1300 (1990).

Although SAIF's attorney apparently recognized the fact that claimant was contending that her condition was related to her "work activities" and attempted to "clarify" the compensability issue, he did not request a continuance, which was his remedy if SAIF was surprised and prejudiced by claimant's raising an occupational disease theory of compensability. Moreover, in this case, there is no showing of surprise or prejudice. Accordingly, we conclude that the Referee properly exercised her discretion in allowing an occupational disease theory to be raised.

Finally, we note that, contrary to claimant's contingency to her concession that SAIF was correct in arguing that an occupational disease theory had not been raised at hearing, claim preclusion would preclude claimant from future litigation of the compensability of her current condition under an occupational disease theory under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980).

ORDER

The Referee's order dated March 18, 1994 is affirmed.

In the Matter of the Compensation of
JOHN L. ROGERS, Claimant
WCB Case No. 93-12216
ORDER ON REVIEW
Dennis W. Skarstad, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Neal's order which: (1) upheld the insurer's denial of claimant's low back injury/occupational disease claim; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. In his brief, claimant contends that the Referee erred in admitting impeachment evidence in violation of the Oregon Evidence Code. On review, the issues are evidence, compensability, penalties and attorney fees.

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

Claimant contends that the Referee incorrectly admitted evidence of credit card fraud offered by the insurer to impeach claimant's credibility. Claimant asserts that the Referee's ruling violated Rule 608 of the Oregon Evidence Code, which prohibits proof of specific instances of misconduct for the purpose of attacking the credibility of a witness.

In deciding this case we give no weight to the evidence concerning allegations of credit card fraud and do not base our decision on that evidence.

ORDER

The Referee's order dated January 19, 1994 is affirmed.

In the Matter of the Compensation of
SNOWDEN A. GEVING, Claimant
WCB Case No. 93-09857
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Thomas Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Davis' order that: (1) awarded a penalty under ORS 656.262(10) for the SAIF Corporation's unreasonable delay in responding to claimant's home health care reimbursement claim; (2) declined to award a "penalty-related" attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation; and (3) declined to award a carrier-paid attorney fee award under ORS 656.386(1). SAIF has moved the Board for an order striking claimant's reply brief. On review, the issues are penalties, attorney fees, and motion to strike. We deny the motion, affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's "de facto" denial of claimant's claim for home health care. That portion of the order is not appealed.

In addition, the Referee found that the denial was not unreasonable, reasoning that claimant's conduct prevented SAIF from obtaining relevant information. We adopt and affirm the Referee's opinion that SAIF's "de facto" denial was not unreasonable.

The Referee determined that SAIF's failure to timely accept or deny the claim amounted to unreasonable resistance to the payment of compensation. Consequently, the Referee directed SAIF to pay a penalty of 25 percent of home health care reimbursement that SAIF would be providing to claimant. Finally, the Referee declined to award an attorney fee under ORS 656.386(1) or a "penalty-related" fee under ORS 656.382(1). The Referee reasoned that a ".386(1)" attorney fee was not authorized under SAIF v. Allen, 124 Or App (1993) and that a ".382(1)" attorney fee was not available under Corona v. Pacific Resource Recycling, 125 Or App 47 (1993).

Claimant contends that the Referee erred in awarding a penalty, rather than a "penalty-related" attorney fee. In this regard, claimant argues that there is no basis for a penalty (i.e., no "amounts due" under the claim) because the cost of claimant's home health care was undetermined at the time of hearing. See ORS 656.262(10). We disagree.

There were "amounts due" as of the date of hearing, because the "de facto" denied claim was found compensable and benefits under the claim had not been paid. Thus, even though the exact amount of unpaid compensation had not been determined, the penalty assessment was appropriate. Moreover, because a penalty and a penalty-related attorney fee may not be assessed for a single instance of unreasonable conduct (the unreasonable failure to timely accept or deny the claim or pay the disputed benefits), we are not authorized to award an attorney fee under ORS 656.382(1). See Oliver v. Norstar, 116 Or App 333 (1992).

Finally, the Referee declined to award an attorney fee under ORS 656.386(1), because the compensability of claimant's injury was not at issue and the Court of Appeals' decision in SAIF v. Allen, supra, prohibited a fee under these circumstances. However, since the Referee's order, the Supreme Court has addressed the availability of attorney fees for prevailing over a "de facto" denial of a medical bill. See SAIF v. Allen, 320 Or 192 (1994).

After reviewing the text and context of ORS 656.386(1), the Court concluded that a claim for medical benefits is a "claim for compensation" under the statute. The Court held that the Board had not erred in concluding that the carrier's conduct constituted a denial of the claim where the carrier had neither accepted, denied, nor paid the medical bills within 90 days and, in responding to claimant's hearing request, the carrier had replied that the bills had been timely paid. SAIF v. Allen, supra. Based on the carrier's conduct, the Allen Court further determined the carrier's denial was not confined to the issue of the amount of compensation or extent of disability. Id.

Here, SAIF neither accepted, denied, nor paid the home health care bills within 90 days. Moreover, at hearing, SAIF's counsel expressly questioned whether claimant's home health care was related to his injury. (Tr. 5). Under these circumstances, we conclude that SAIF's conduct constituted a claim denial not confined to the amount of compensation or extent of disability. Accordingly, since claimant finally prevailed at hearing in overturning SAIF's "de facto" denial of claimant's claim for home health care services, we conclude that claimant is entitled to an attorney fee for his counsel's services at the hearing level. ORS 656.386(1).[1]

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the hearing level concerning SAIF's "de facto" denial of claimant's claim for home health care services is $2,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the medical bill issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant's counsel is receiving 50 percent of the penalty assessment under ORS 656.262(10). Finally, claimant is not entitled to an attorney fee for services related to securing his attorney fee award at hearing. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated January 31, 1994, as reconsidered March 21, 1994, is reversed in part and affirmed in part. That portion of the order that declined to assess an attorney fee under ORS 656.386(1) is reversed. For his services at the hearing level in connection with SAIF's "de facto" denial, claimant's counsel is awarded a $2,000 attorney fee, payable by SAIF. The remainder of the order is affirmed.

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[1] We acknowledge SAIF's motion to exclude claimant's reply brief which raises the ".386(1)" fee issue. We deny the motion for the following reasons. Because the issue was raised at hearing and addressed in the Referee's order, it is subject to our review. See Destael v. Nicolai Co., 80 Or App, 596, 600-01 (1986). In light of this determination, we have also considered SAIF's supplemental response.

In the Matter of the Compensation of
HAROLD J. LAWRENCE, Claimant
WCB Case No. 93-10110
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee T. Lavere Johnson's order which: (1) reduced claimant's award of unscheduled permanent disability for a neck and upper back condition from 18 percent (57.60 degrees), as granted by an Order on Reconsideration, to 14 percent (44.80 degrees); and (2) declined to award claimant an assessed attorney fee for successfully defending against the self-insured employer's request for a reduction of his scheduled permanent disability award. On review, the issues are extent of unscheduled permanent disability and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his finding that claimant was employed as a "machinist" at Maris Dental.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on June 27, 1991 while performing employment duties that required lifting and exertion. Claimant experienced neck pain, bilateral shoulder pain and a loss of range of motion in the cervical area. Claimant was diagnosed with a cervical and upper thoracic strain, which the employer accepted as the compensable condition.

The claim was closed by Determination Order on April 8, 1993, with an award of 12 percent unscheduled permanent disability and 7 percent scheduled permanent disability for loss of use or function of the left arm. Claimant requested reconsideration. Following completion of Dr. Smith's medical arbiter's examination, an Order on Reconsideration issued on August 6, 1993, increasing claimant's unscheduled permanent disability award to 18 percent and scheduled permanent disability award to 14 percent. The employer requested a hearing contesting the reconsideration order. Claimant cross-requested a hearing.

The Referee affirmed the reconsideration order's award of scheduled permanent disability, but decreased claimant's unscheduled permanent disability award from 18 to 14 percent. The Referee also denied claimant's counsel's request for an attorney fee pursuant to ORS 656.382(2) for successfully defending the scheduled award, reasoning that the total compensation in the reconsideration order had been reduced.

On review, claimant contends that the Referee erred in reducing his award of unscheduled permanent disability and that he is entitled to an increase in unscheduled permanent disability above that which the reconsideration order awarded. Moreover, claimant asserts that he is entitled to an attorney fee under ORS 656.382(2) for successfully defending his scheduled permanent disability from disallowance or reduction at hearing. We agree with claimant's contentions.

Unscheduled Permanent Disability

In his reply brief, claimant concedes that he has the burden of proving the extent of his unscheduled permanent disability because he cross-requested a hearing asserting that his permanent disability should be increased and because he has filed this appeal. Cf. Roberto Rodriguez, 46 Van Natta 1722, on recon 46 Van Natta 2233 (1994) (where insurer was the only party registering dissatisfaction with an Order on Reconsideration, it had the burden of proving that the "standards" were incorrectly applied under ORS 656.295(5)). Assuming without deciding that claimant is correct, we find that he sustained his burden of proof.

The applicable standards are those in effect when the April 8, 1993 Determination Order closed the claim (WCD Admin. Ord. 6-1992). OAR 438-10-010. We now proceed with the calculation of claimant's unscheduled permanent disability. The parties agree that claimant is not entitled to any value for age and formal education. The most significant area of disagreement concerns the skills factor.

The skills value is determined by the highest Specific Vocational Preparation (SVP) achieved by a worker in the 10 years prior to determination. The SVP value is obtained from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT). To determine the skills value for a worker, the DOT job title for each job the worker performed during the 10 years prior to determination is identified. With respect to each job title, a determination is made about whether the worker has met the SVP number assigned to such job by the SCODDOT. In order to meet the SVP number for a particular job, the worker must have "remained in the field" for the training time which corresponds to the SVP number assigned to that job title. See former OAR 436-35-300(4).

The Referee based claimant's skills value on his employment at Maris Dental, finding that claimant was employed as a "machinist." (DOT 600.280-022, SVP 7). According to the Referee, this employment entitled claimant to a value of 1 for skills. See former OAR 436-35-300(4). Claimant contends that the DOT classification assigned by the Referee for his employment at Maris Dental is inappropriate. We agree.

Claimant credibly testified that he ran a milling machine and lathe between 1983 and 1987. However, the machines were set up by others and claimant was instructed in the operation of the machines. (Tr. 12). If there was a need for an adjustment in a machine, a supervisor would have to fix the machine, unless the problem was very minor. (Tr. 14). Although it appears that claimant did read some blueprints, his testimony did not establish that this constituted a significant aspect of his job. (Tr. 13).

To qualify as a "machinist" under the DOT, claimant would have had to set up machines; fit and assembled machined parts into complete units, applied knowledge of machine shop theory, shop mathematics, machinability of materials and layout techniques; and studied blueprints, sketches, drawings and manuals, etc. No evidence was presented establishing that claimant possessed these kinds of skills. We are, therefore, not persuaded that claimant's employment was sufficiently skilled to qualify for the "machinist" classification in the DOT.

Nor do we find claimant's employment at Maris Dental sufficiently skilled to qualify for the classification of Machine Set-Up Operator (DOT 600.380-018, SVP 6), which the Referee suggested as an alternative to the category of machinist. This classification also required that claimant set up his machines, as well as engage in sophisticated machine operation. Claimant's testimony does not establish that he performed the duties that would qualify him for this position either. Instead, based on claimant's description of his duties, we find that a more appropriate classification for determining claimant's skills value is DOT 619.685-062 (Machine Operator II), which has an SVP 3. Under this classification, claimant is entitled to a value of 3 for skills.

Given our finding with respect to claimant's skills value, we further conclude that claimant is also entitled to a value of 1 under former OAR 436-35-300(5). In addition to not achieving an SVP of 5 or greater in the 10 years preceding the determination, claimant does not currently hold a certificate or license for employment in an Oregon job with an SVP of 4 or less.

Thus, the sum of claimant's age and education values is 4. Pursuant to former OAR 436-35-280, this sum is multiplied by the adaptability value. The adaptability value is determined by a comparison of a worker's "prior strength" with his residual functional capacity (RFC). See former OAR 436-35-270(3)(d),(g); 436-35-310.

Here, the parties agree that claimant's prior strength demand was "heavy." The area of disagreement concerns claimant's residual functional capacity. The medical arbiter recommended that claimant be restricted to "medium" employment with no more than 1 hour of sitting and no awkward cervical spine positions, i.e., crawling. (Ex. 71-4). The Referee determined that such restrictions on claimant's work release placed claimant in the medium/light residual functional category. We agree with the Referee. See former OAR 436-35-310(3); 436-35-270(3)(e).

Although Dr. Belza, claimant's treating physician, did not place sitting or crawling restrictions on claimant when he was declared medically stationary, Dr. Belza did restrict repetitive overhead work. (Ex. 40-9). This would preclude frequent performance of climbing and reaching. Thus, Dr. Belza's restriction would also qualify claimant as a "restricted" worker under OAR 436-35-270(3)(e). Therefore, even under Dr. Belza's work release, claimant's residual functional capacity is medium/light.

Because claimant's prior strength demand was "heavy" and his RFC is "medium/light," claimant is entitled to a value of 4 for adaptability. former OAR 436-35-310(3). The product of age and education (4) times adaptability (4) is 16.

The final step in calculating claimant's permanent disability is the addition of claimant's impairment value to the above product. The Referee determined that claimant's impairment value is 10, based on reduced cervical and thoracic range of motion documented in Dr. Smith's medical arbiter's report. Neither party disputes the Referee's calculation of permanent impairment to that extent. The only disagreement is claimant's contention that he is entitled to 2 percent impairment for reduced range of shoulder motion as found by Dr. Smith. See former OAR 436-35-330(9).

The employer does not directly dispute claimant's assertion, except by concluding that the Referee's calculation of impairment based on cervical and thoracic impairment was correct. Although the arbiter is not required to report only impairment findings due to the compensable injury, see Julie A. Widby, 46 Van Natta 1065 (1994), there is no evidence that the arbiter rated impairment due to other causes. Thus, we find that claimant's shoulder impairment findings are related to the compensable injury. See David J. Schafer, 46 Van Natta 2298 (1994).

Therefore, we conclude that claimant's impairment value is 12. When added to the product of age and education times adaptability (16), the sum is 28. Claimant's unscheduled permanent disability is, therefore, 28 percent. We modify the Referee's order accordingly.

Attorney Fees

As previously noted, claimant contends that he is entitled to an attorney fee pursuant to ORS 656.382(2) for successfully defending the reconsideration order's award of scheduled permanent disability against the employer's request for a reduction. The Referee refused to make such an award, finding that claimant's total award of scheduled and unscheduled permanent disability had been reduced.

In light of our conclusion concerning claimant's unscheduled permanent disability award, it follows that the employer's request for a reduction of claimant's award has not been successful. Thus, claimant would be entitled to a carrier-paid attorney fee for his counsel's services at hearing. In any event, even if we had not increased claimant's unscheduled award, we would still find that claimant was entitled to an attorney fee award under ORS 656.382(2) for successfully defending his scheduled award at hearing. See Debra L. Cooksey, 44 Van Natta 2197, 2198 (1992).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing 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 the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Because we have increased claimant's unscheduled award, 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 (14 percent unscheduled permanent disability; the difference between the Referee's 14 percent award and our 28 percent award), not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1). In the event that a portion of the substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated January 26, 1994 is modified in part and reversed in part. In lieu of the Referee's award of unscheduled permanent disability and in addition to the Order on Reconsideration award of 18 percent (57.6 degrees), claimant is awarded 10 percent (32 degrees), for a total unscheduled permanent disability award of 28 percent (89.6 degrees). Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation (14 percent unscheduled permanent disability) created by this order, not to exceed $3,800. In the event that a portion of this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane Volk, supra. That portion of the Referee's order which declined to award an attorney fee pursuant to ORS 656.382(2) is reversed. Claimant is awarded a fee of $1,000 for services at hearing regarding the permanent disability issues, payable by the employer. The remainder of the Referee's order is affirmed.

November 15, 1994 Cite as 46 Van Natta 2359 (1994)

In the Matter of the Compensation of
LARRY L. SCHUTTE, Claimant
Own Motion No. 90-0333M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys

By letter dated June 13, 1990, the self-insured employer submitted to the Board claimant's request for temporary disability compensation for his compensable October 9, 1980 low back injury. Claimant's aggravation rights expired July 27, 1989. On July 18, 1990, the Board postponed action regarding the own motion matter until pending litigation on related matters was resolved. This pending litigation involved whether claimant had sustained a worsening of his October 9, 1980 injury or a new low back injury for which the employer was responsible. (WCB Case Nos. 90-06482, 91-11252). In addition, the issues of premature closure and extent of permanent disability, including permanent total disability, were raised in regard to a January 26, 1990 Determination Order that had closed a prior aggravation of the October 9, 1980 injury. (WCB Case No. 92-15997).

We note that the employer initially denied claimant's proposed low back surgery as being not reasonable and necessary. However, subsequently, the employer authorized the surgery, which claimant underwent on December 11, 1991.

On February 25, 1992, the parties entered into a stipulation in which they agreed that the employer would pay claimant time loss benefits under the 1980 injury claim. These benefits were to commence the date of claimant's most recent surgery, which occurred on December 11, 1991. The

parties also agreed that claimant retained his right to pursue his contention that the need for surgery was related to a new injury that allegedly occurred while claimant was participating in an Authorized Training Program. This stipulation was approved by the Board in its own motion capacity.

In addition, on February 25, 1992, the Board issued an Own Motion Order acknowledging the above stipulation. The Board noted that the stipulation was designed to permit claimant to receive temporary disability compensation pending resolution of litigation regarding whether claimant's need for low back surgery was due to a worsening of the October 9, 1980 injury or a new injury for which the employer was responsible. The order also indicated that action on the own motion matter remained postponed pending resolution of the litigation.

By order dated December 23, 1992, Referee Mongrain noted that the parties preserved the issues of extent of permanent and temporary disability and premature closure. The Referee also concluded that claimant's low back condition and the need for surgery resulted from a worsening of his 1980 compensable injury. (WCB Case Nos. 90-06482 and 91-11252). Claimant requested Board review. By order dated October 26, 1993, the Board affirmed Referee Mongrain's decision that claimant's claim was properly processed as an aggravation of the 1980 injury rather than as a new injury. The Board's order has become final.

By order dated December 30, 1993, Referee T. Lavere Johnson addressed the issue of the extent of permanent disability in regard to the January 26, 1990 Determination Order. (WCB Case No. 92-15997). Referee Johnson concluded that claimant was permanently and totally disabled effective November 8, 1989. The employer requested Board review of the order. By order dated October 12, 1994, the Board affirmed Referee Johnson's order.

Thus, all pending litigation has been resolved and we proceed to determine what, if any, further own motion action is required.

We note that the February 25, 1992 Own Motion Order approved the payment of temporary disability benefits in conjunction with the February 25, 1992 Stipulation. Furthermore, that stipulation was implicitly based on the parties' acknowledgment that the employer was responsible for claimant's need for low back surgery. Apparently on that basis, the parties agreed that the employer would pay temporary disability compensation based on the 1980 claim, pending resolution of the "new injury" issue. We conclude that the stipulation, in effect, constituted a voluntary reopening of the own motion claim, contingent on a determination that the employer was responsible for claimant's current low back condition due to a worsening of the 1980 injury. ORS 656.278(4).

A carrier is permitted to voluntarily reopen an own motion claim. ORS 656.278(4). However, ORS 656.625(1) provides that a prerequisite to any recovery from the Reopened Claims Reserve is compliance with a Board order issued pursuant to its own motion authority under ORS 656.278 directing the carrier to compensate a claimant. SAIF v. Holmstrom, 113 Or App 242 (1992); OAR 436-45-010. Therefore, we proceed to the merits of this case pursuant to ORS 656.278.

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

As noted above, it has been finally determined that the employer is responsible for claimant's current low back condition and resulting surgery based on a worsening of the 1980 compensable injury. Thus, we are persuaded that claimant's compensable 1980 injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning December 11, 1991, the date he was hospitalized for surgery. Furthermore, the claim is to be closed pursuant to OAR 438-12-055 when claimant is medically stationary.

We note that the employer closed the claim pursuant to OAR 438-12-055 on March 16, 1993, when it issued a Notice of Closure regarding the own motion claim. The employer declared claimant medically stationary as of March 15, 1993 and indicated that temporary disability benefits had been paid from December 11, 1991 through March 8, 1993. The Notice of Closure was not appealed.

We also note that, by order dated October 12, 1994, the Board has determined that claimant is permanently and totally disabled effective November 8, 1989. However, claimant is not entitled to double compensation for the period from December 11, 1991 through March 8, 1993, during which time he was paid temporary total disability compensation pursuant to the February 25, 1992 Stipulation.

Furthermore, our authorization of payment of temporary disability compensation beginning on December 11, 1991 does not constitute an additional payment of temporary disability payment. Rather, it is an authorization to pay these benefits pursuant to our authority under ORS 656.278. Given the fact that, subsequent to the employer's voluntary reopening, claimant has been determined to be permanently and totally disabled effective November 8, 1989, a period which includes the voluntarily reopened period, our award is to be offset against the permanent total disability award for the period from December 11, 1991 through March 8, 1993.[1]

In addition, as discussed above, claimant's own motion claim was closed by Notice of Closure on March 16, 1993.

IT IS SO ORDERED.

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[1] The February 25, 1992 Stipulation noted that one of its purposes was to acknowledge that "[t]the Own Motion Division of the Workers' Compensation Board agrees that should a referee determine that there has been no new injury and the Board determines that the time loss benefits should be processed in the 1980 claim under ORS 656.278, [the employer] will be reimbursed for time loss paid hereunder by the Own Motion Division as authorized under ORS Chapter 656 and OAR Chapter 436."

We interpret this provision to authorize reimbursement from the Reopened Claims Reserve under ORS 656.625. However, subsequent to the stipulation, the Court of Appeals held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, supra. The court held that the Director has authority to reimburse carriers for the amounts awarded by the Board under ORS 656.278. Id. Therefore, notwithstanding the above quoted stipulation language, the Board cannot authorize reimbursement from the Reserve. The employer must seek such reimbursement from the Director.

Member Gunn specially concurring.

Claimant has been awarded permanent total disability compensation effective November 8, 1989. The employer is liable for the payment of that award. I agree that claimant is not entitled to double compensation for the period from December 11, 1991 through March 8, 1993, during which time he was paid temporary disability compensation under the February 25, 1992 Stipulation. Thus, I agree that the employer may offset the amount of temporary disability compensation paid during that period against the permanent total disability compensation owed claimant. However, I specially concur because I find it peculiar that, under the facts of this case, the employer will be able to reduce its liability for claimant's permanent total disability compensation by seeking reimbursement from the Reopened Claims Reserve.

By the publishing of this order authorizing the reopening of the own motion claim, the employer may seek reimbursement from the Reserve for the temporary disability compensation paid under the own motion claim. ORS 656.625; SAIF v. Holmstrom, supra. Thus, although the employer has been found liable to claimant for an award of permanent total disability compensation effective November 8, 1989, the employer may reduce its liability by the amount of the reimbursement it receives from the Reserve. Liability for payment of permanent total disability is normally the responsibility of the carrier against which such an award is made. However, here, a piece of that liability will be borne by the Reserve. Although there is nothing improper about this, I find it peculiar.

In the Matter of the Compensation of
ARTURO BARRON, Deceased, Claimant
WCB Case No. 92-13475
ORDER ON REVIEW (REMANDING)
Estell & Bewley, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The decedent's putative statutory beneficiary, (Julia Mendoza, hereinafter "Mendoza"), requests review of Referee Michael V. Johnson's order that dismissed a request for hearing from the SAIF Corporation's denial of a claim for death benefits in connection with decedent's fatality. On review, the issue is the propriety of the Referee's dismissal order. We vacate and remand.

The following procedural history appears from the parties' allegations and briefs on review.

The decedent was killed in a car accident on April 14, 1992. He is allegedly survived by a wife (Mendoza) and four minor children who reside in Mexico. Juan Marquez signed a Form 801 for the decedent. After the employer was found to be a noncomplying employer, the Department of Insurance and Finance (DIF)[1] referred the claim to SAIF on July 20, 1992. The referral letter states "Please process this claim for injury to [decedent]" and indicates that copies were sent to the "Estate of Arturo Barron," the employer and to two attorneys.

On July 27, 1992, SAIF wrote to one of those attorneys, stating that the documentation from DIF indicated that he was representing someone and asking what legal entity he represented. The attorney responded that he represented "the Estate of Arturo Barron in this matter" and that a probate proceeding had been filed. On August 20, 1992, SAIF sent a letter to the attorney that said: "Enclosed is a beneficiary form for your client to complete. Please note that we must have copies of the marriage certificate and all birth certificates in order to process the claim." SAIF does not contest the representation on review by Mendoza's current attorney that this material was supplied to SAIF before the claim was denied.

On September 29, 1992, SAIF sent a denial of the claim for "fatal benefits in connection with a fatality" to "the Estate of Arturo Barron," which was addressed to the decedent's former address. There is no indication that SAIF sent a copy to Mendoza. SAIF denied the claim because "this fatality did not arise from [decedent's] employment." On October 15, 1992, a request for hearing was made by the "Estate of Arturo Barron, dscd., Juan Marquez, personal representative." The request was signed by the current attorney for Mendoza.

On January 12, 1993, SAIF filed a motion to dismiss on the basis that the hearing request was invalid because the statutory beneficiaries had not requested a hearing and there was no party represented by the attorney with standing to request a postponement of the hearing. On March 31, 1993, a memorandum in response to the motion to dismiss was filed, as well as a "Supplemental Request for Hearing" with copies of an attorney retainer agreement between the current attorney and Mendoza.

The Referee dismissed the request for hearing, reasoning that neither the estate nor the personal representative were entitled to file a request for hearing. The Referee relied on ORS 656.204 and ORS 656.218(4) and (5).

Under ORS 656.218(4), if the worker dies before filing a request for hearing, the persons described in ORS 656.218(5) "shall be entitled to file a request for hearing and to pursue the matter to final determination as to all issues presented by the request for hearing." ORS 656.218(5) provides:

> "The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204."

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[1] The Department of Insurance and Finance has since been renamed the Department of Consumer and Business Services.

Relying on Trice v. Tektronix, Inc., 104 Or App 461 (1990), SAIF contends that there has not been a valid hearing request because the statutory beneficiaries have not requested a hearing. SAIF acknowledges that there is a factual issue as to whether the denial issued to the "estate" provided actual or constructive notice to the statutory beneficiaries. SAIF argues, however, that until the statutory beneficiaries request a hearing, there is no one with standing to pursue this matter at hearing or to request a postponement.

In Trice v. Tektronix, Inc., supra, the claimant died after she had filed a request for hearing on the issue of temporary total disability benefits for her compensable stress claim. At the time of her death, she was unmarried and was not survived by any minor children. The employer filed a motion to dismiss on the ground that the claimant had left no statutory beneficiaries to pursue her request for hearing. The claimant's 28-year-old daughter, as the personal representative of her estate, moved for an order substituting her for the claimant.

The Trice court held that the right to pursue a deceased claimant's hearing request is limited under ORS 656.218 to those who are entitled to death benefits under ORS 656.204. 104 Or App at 465. The court noted that the claimant was unmarried when she died and had no minor children. The court concluded that the personal representative is not a statutory beneficiary entitled to pursue the hearing request. Id.

We find this case distinguishable from Trice v. Tektronix, Inc., supra. First, that case did not involve the filing of an initial claim. Rather, the claimant in Trice had already filed a claim, which had been previously found compensable in a prior adjudication. After filing a hearing request seeking unpaid temporary disability, the claimant died. The personal representative sought an order to substitute her for the claimant. Finally, and most importantly, at the time of the employer's motion to dismiss, there was no contention that there was a statutory beneficiary to pursue the hearing request.

Here, in contrast, the decedent died before filing an initial injury claim. The hearing request has been filed in response to SAIF's denial of the initial claim for death benefits based on its contention that the decedent's death did not arise out of the course and scope of his employment. In other words, the hearing request is designed to litigate the issue of whether the decedent's death resulted from a compensable injury. In the absence of such a determination, there is no entitlement to compensation, regardless of the number of potential statutory beneficiaries.

Moreover, unlike in Trice, the record contains an allegation that the decedent has statutory beneficiaries. In fact, SAIF asserted in its motion to dismiss that "ORS 656.204(2) would apparently apply to Mr. Barron, age 36 and married, who left a family in Mexico." If found as fact, we would concur with SAIF's assertion in that ORS 656.204(2) provides that a surviving spouse and minor children are entitled to benefits "[i]f death results from the accidental injury."

Survivor rights are independent and not derivative of the injured worker's rights. Fossum v. SAIF, 289 Or 787 (1980). Under ORS 656.218(4), a person entitled to receive death benefits may file a request for hearing and pursue the matter to final determination. We conclude that the request for hearing satisfies this statutory prerequisite, as well as the requirement in ORS 656.319(1)(a) that the request for hearing be filed within 60 days of the denial. We base these conclusions on the following reasoning.

SAIF denied the claim on September 29, 1992, on the basis that the fatality did not arise from the decedent's employment. SAIF issued the denial to the "Estate of Arturo Barron" and addressed it to the decedent's former address. There is no indication that SAIF sent a denial letter to Mendoza. On October 15, 1992, within 60 days from the denial, a request for hearing was made by the "Estate of Arturo Barron, dscd., Juan Marquez, personal representative."

In light of the subsequent submission of an executed retainer agreement between the current attorney and the decedent's alleged widow (Mendoza), the record supports a conclusion that the attorney who signed the request for hearing filed it on behalf of the decedent's putative beneficiaries. Although the request for hearing shows "claimant's" name/address as "Estate of Arturo Barron, dscd., Juan Marquez, personal representative," we do not consider that phrase determinative, particularly when the designation was in response to SAIF's denial of fatality benefits issued to "the Estate of Arturo Barron."

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 Referee dismissed the hearing request on the ground that no statutory beneficiary had requested a hearing, no fact finding was made to determine whether there are, in fact, statutory beneficiaries entitled to receive death benefits in the event that the decedent's death is found to be compensable. In light of such circumstances, we find the record incompletely and insufficiently developed to make such a determination. See Velma L. Vetternack, 46 Van Natta 929 (1994) (remanded to determine whether a statutory beneficiary existed to continue the claimant's claim).

Accordingly, we vacate the Referee's order dated November 24, 1993, as reaffirmed and republished on February 16, 1994. This matter is remanded to Referee Michael V. Johnson for the presentation of evidence regarding the issue of whether a statutory beneficiary exists to pursue the hearing request and, if so established, the presentation of evidence regarding the compensability of the claim and any other issue raised by the hearing request. These proceedings may be conducted (separately or in consolidation) in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7).

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD P. BECKEL, Claimant
WCB Case No. 93-15223
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Garaventa's order that: (1) upheld the SAIF Corporation's denial of claimant's spinal stenosis; 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, with the following supplementation.

On August 25, 1993, claimant sustained another work-related back strain. (Exs. 15, 21).

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the Referee's "Conclusions and Opinion," with the exception of the second full paragraph on page 3 of the order, and with the following supplementation.

Dr. Waldram, treating surgeon, concluded that claimant has a preexisting spinal stenosis that combined with his August 25, 1993 compensable work injury to result in a L4-5 disc herniation. SAIF accepted the herniated disc, but denied the spinal stenosis. Claimant requested a hearing regarding the denied spinal stenosis. The Referee concluded that, because there was no evidence that claimant's work activities caused his spinal stenosis, claimant had failed to establish the compensability of the spinal stenosis under ORS 656.802(2).[1]

Claimant argues that, because Dr. Waldram concluded that the major contributing cause of his herniated disc was the work accident combined with the preexisting spinal stenosis, he has established the compensability of his spinal stenosis under ORS 656.005(7)(a)(B). We disagree.

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[1] The Referee also concluded that claimant had failed to establish that a compensable injury was the major contributing cause of his spinal stenosis. We understand the basis of that analysis to be ORS 656.005(7)(a)(A). Claimant does not contest that portion of the Referee's order.

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 that the compensable injury is and remains the major contributing cause of the disability or need for treatment." (Emphasis added).

On its face, that statute provides that the resultant condition, not the preexisting condition, is compensable to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment. In this case, the persuasive medical evidence establishes that claimant's preexisting spinal stenosis, in combination with his August 25, 1993 work injury, resulted in the L4-5 disc herniation, which SAIF has already accepted. (Exs. 30, 31-5). The evidence does not establish the independent compensability of claimant's spinal stenosis under ORS 656.005(7)(a)(B).[2]

ORDER

The Referee's order dated April 14, 1994 is affirmed.

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[2] In his report, examining physician, Dr. Fuller, stated that "spinal stenosis is a constriction of the spinal cord [caused] by a combination of bulging discs and bony overgrowth." (Ex. 31-5). There is no evidence that claimant's August 1993 work injury caused the spinal stenosis. Rather, by accepting claimant's L4-5 disc herniation, it appears that SAIF believed that the disc herniation was a consequence or result of the August 1993 injury. In any event, in this case, it is the disc herniation, not the spinal stenosis, that is compensable.

November 16, 1994 Cite as 46 Van Natta 2365 (1994)

In the Matter of the Compensation of
JULIE E. BOWERS, Claimant
WCB Case No. 93-06313
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of that portion of Referee Thye's order that set aside its denial of claimant's consequential psychological condition. On review, the issue is compensability.

We adopt and affirm the Referee's order. See SAIF v. Freeman, 130 Or App 81 (1994) (Psychological condition remained compensable because the medical evidence established that claimant became depressed when his ability to work was diminished as a result of his compensable injury); Albert H. Olson, 46 Van Natta 1848 (1994) (Consequential psychological condition was compensable because claimant's compensable injury and its sequelae, included injury-related inability to continue employment because of injury-related disability, were the major contributing cause of his depression).

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 $1,325, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, the value to claimant of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated October 15, 1993 is affirmed. For services on review, claimant's counsel is awarded a $1,325 attorney fee, payable by the insurer.

In the Matter of the Compensation of
SARAH E. ECKHART, Claimant
WCB Case No. 93-15040
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Crumme's order which affirmed an Order on Reconsideration that awarded 9 percent (28.8 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed an Order on Reconsideration that awarded 9 percent unscheduled permanent disability. We affirm the Referee's order, but for different reasons.

The parties stipulated to the value of (4) for age and education[1] and the value of (5) for impairment. Thus, the sole dispute between the parties concerning the unscheduled disability award is the correct value for the adaptability factor.

Subsequent to the Order on Reconsideration, 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 436-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant became medically stationary on May 25, 1993, and her claim was closed by Notice of Closure on June 17, 1993. 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. Therefore, the "standards" in effect on the date of the June 17, 1993 Notice of Closure apply. 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 RFC at the time of determination. Former OAR 436-35-310(1) (WCD Admin. Order 6-1992). For workers who at the time of determination have a physician's release for regular work, or have either returned to or have the RFC for regular work or work requiring greater strength than work performed on the date of injury, the value for the adaptability factor is 0. Former OAR 436-35-310(2) (WCD Admin. Order 6-1992).

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[1] The parties stipulated to the age and education value under former OAR 436-35-290 and 300 (temp). As noted above, these temporary rules have expired. We have previously held that parties may not stipulate to an application of the incorrect disability rating standards. See Randal L. Brown, 44 Van Natta 1726 (1992). The Referee accepted all the parties' stipulations, even though the total value for claimant's age and education was stipulated to under an application of the incorrect disability rating standards. However, even though that stipulation is contrary to the correct standards, because the adaptability multiplier is 0 and any change in the stipulated value would result in the same outcome, we find no need to disturb the stipulation on review.

We note, moreover, that because claimant returned to her regular work, the value for the education factor would be 0. Former OAR 436-35-300(2) (WCD Admin. Order 6-1992).

Here, claimant worked as a Fast Food Worker (DOT 311.472-010) at the time of injury, which had a strength demand of light. On November 11, 1993, Dr. Levin noted that claimant had returned to work waiting tables at a restaurant. He restricted claimant to light work and opined that claimant was capable of returning to her job at injury. (Ex. 15). Consequently, we conclude that the value for claimant's adaptability factor is 0. Former OAR 436-35-310(2) (WCD Admin. Order 6-1992).

Former OAR 436-35-280(4) provides that the values for age and education are added together. Former OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. Former OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (4) is multiplied by the adaptability value (0), the total is 0. When this value is added to the value for impairment (5), the result is 5. Therefore, claimant's unscheduled permanent disability under the "standards" is 5 percent.

However, because SAIF did not request a reduction in claimant's award, we affirm the Referee's order that upheld the Order on Reconsideration.

ORDER

The Referee's order dated April 18, 1994 is affirmed.

Board Member Hall specially concurring.

For the following reasons, I offer this concurrence. I am bound by the majority's decision in Michelle Cadigan, 46 Van Natta 307 (1994). Nevertheless, I continue to adhere to the analysis and reasoning expressed in the dissent in Cadigan. The Director's "adaptability" rule (OAR 436-35-310; WCD Admin. Order 93-056) is contrary to the statutory mandate to determine "loss of earning capacity". By granting a zero adaptability value when a worker has returned to "regular" work, that worker is not allowed a value for age, education, and adaptability as required by ORS 656.726(3)(f)(A) and 656.214(5). The historical-legal analysis for such a holding is set forth in the Cadigan dissent.

The recent decision by the Court of Appeals in Garrett v. Still Water Corporation, 130 Or App 679 (1994), does not alter my opinion. In Garrett, the court affirmed without opinion the Board's order in Cornell D. Garrett, 46 Van Natta 340 (1994), which concerned which DOT job description was most applicable in rating the claimant's permanent disability under the "standards." Cadigan was cited by the Board's majority in Garrett for the proposition that the "standards" in effect at the time of the Determination Order or Notice of Closure were to be applied under the circumstances in Garrett. While I registered a single sentence dissent in Garrett (simply citing to the dissent in Cadigan), Garrett neither fully addressed nor resolved the issues of law raised by the dissent in Cadigan.

As of this date, I am unaware of any case in which an appellate court has directly addressed those particular issues of law. Consequently, the concerns raised in the Cadigan dissenting opinion remain unanswered.

In the Matter of the Compensation of
BETTY J. INGLES, Claimant
WCB Case Nos. 93-07057 & 93-08815
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of those portions of Referee Daughtry's order which: (1) set aside its denial of claimant's aggravation claim for an ear condition; and (2) set aside its denial of claimant's claim for a consequential psychological condition. On review, the issues are aggravation and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of that portion of claimant's closing argument which the Referee adopted as part of his factual findings. In its place, we find the following facts.

The insurer referred claimant to an examining psychiatrist, Dr. Parvaresh, who interviewed claimant and performed an M.M.P.I. test. Dr. Parvaresh issued a series of medical reports in which he concluded that claimant's noncompensable kidney condition and elevated cholesterol and triglycerides constituted the major contributing cause of claimant's psychological disorder. (See e.g. Ex. 117-2).

Claimant has also been examined by a psychologist, Dr. Stipek, on two occasions. Dr. Stipek also issued a series of reports and was deposed by the parties. Dr. Stipek diagnosed claimant's psychological condition as major depression. While acknowledging that claimant's noncompensable physical conditions have contributed to claimant's psychological condition, Dr. Stipek, nevertheless, concluded that the major contributing factor in claimant's psychological condition is her inability to work due to pain from her ankle injury, as well as the psychological effects of hearing problems related to her ear injury. (Exs. 113-13, 24, 26, 27, 43; 123-7).

Claimant and an acquaintance (Ms. Russell) testified at the hearing. Claimant testified that she was depressed and preoccupied about her inability to work and to be as active as she once was. (Tr. 24). She also testified to a feeling of hopelessness caused by her ongoing severe ankle pain and hearing problems. (Trs. 24, 26, 27). Claimant further testified that her cholesterol and triglyceride levels were now normal and that she was not concerned about her kidney condition. (Trs. 9, 10). Ms. Russell testified that claimant appeared concerned about her physical problems related to her ankle and ear injuries, but that she was not preoccupied with her kidney condition and elevated triglycerides and cholesterol. (Trs. 61, 62).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had sustained her burden of proving that her compensable ear condition had worsened since the last award or arrangement of compensation in June 1989. We adopt and affirm the Referee's reasoning and conclusions regarding the compensability of claimant's ear aggravation claim.

With respect to claimant's psychological condition, the Referee determined that claimant had sustained her burden of proving that her claim was compensable as an indirect consequence of her compensable 1988 ankle injury. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). In so doing, the Referee relied on Dr. Stipek's medical opinion, rather than Dr. Parvaresh's. On review, the insurer contends that Dr. Parvaresh's opinion is more persuasive. We disagree.

Dr. Parvaresh opined that claimant's concern about her kidney condition and elevated triglyceride and cholesterol was the major factor in her psychological problems. However, claimant testified that she was not concerned about these conditions which were under control. The Referee found claimant to be a credible witness based on his observation of her testimony. Inasmuch as we generally

defer to such demeanor-based credibility findings on review, see Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987), we accept claimant's testimony as truthful. Since Dr. Parvaresh's opinion is based on an inaccurate assumption that claimant is more concerned about her noncompensable conditions than about her pain and inability to work due to the compensable ankle injury, we do not find Dr. Parvaresh's opinion to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Instead, we agree with the Referee that Dr. Stipek's opinion is more persuasive in that it is in accordance with claimant's credible testimony that her psychological problems arose in association with pain and discomfort and inability to work due to her compensable injuries, especially her ankle injury. Since Dr. Stipek's opinion is well reasoned and based on an accurate history, we find that it is persuasive and sufficient to satisfy claimant's burden of proof. Somers v. SAIF, supra. Thus, we affirm the Referee's decision regarding the compensability of claimant's consequential psychological condition. See Albert H. Olson, 46 Van Natta 1848, 1849 (1994) (depression compensable as a consequence of claimant's injury and related sequelae, including job loss and attendant loss of self-esteem).

Claimant's counsel is entitled to attorney fees for services on review concerning the compensability and aggravation 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 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 April 15, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

November 16, 1994 Cite as 46 Van Natta 2369 (1994)

In the Matter of the Compensation of
ROGUE RODRIGUEZ-FERNANDEZ, Deceased, Claimant
WCB Case No. 92-13476
ORDER ON REVIEW (REMANDING)
Estell & Bewley, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The decedent's putative statutory beneficiaries, (Santos Rodriguez and Maria Fernandez, hereinafter "decedent's parents"), request review of Referee Michael V. Johnson's order that dismissed a request for hearing from the SAIF Corporation's denial of a claim for death benefits in connection with decedent's fatality. On review, the issue is the propriety of the Referee's dismissal order. We vacate and remand.

The following procedural history appears from the parties' allegations and briefs on review.

The decedent was killed in a car accident on April 14, 1992. He is allegedly survived by his parents who reside in Mexico. Lucio Fernandez signed a Form 801 on June 4, 1992 for the decedent. After the employer was found to be a noncomplying employer, the Department of Insurance and Finance (DIF)[1] referred the claim to SAIF on July 20, 1992. The referral letter states "Please process this claim for injury to [decedent]" and indicates that copies were sent to the "Estate of Rogue Rodriguez-Fernandez," the employer and to two attorneys.

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[1] The Department of Insurance and Finance has since been renamed the Department of Consumer and Business Services.

On September 29, 1992, SAIF sent a denial of the claim for "fatal benefits in connection with a fatality" to "the Estate of Rogue Rodriguez-Fernandez," which was addressed to the decedent's former address. There is no indication that SAIF sent a copy to decedent's parents. SAIF denied the claim because "this fatality did not arise from [decedent's] employment." On October 15, 1992, a request for hearing was made by the "Estate of Rogue Rodriguez-Fernandez, Lucio Fernandez, personal representative." The request is signed by the current attorney for decedent's parents.

On January 12, 1993, SAIF filed a motion to dismiss on the basis that the hearing request was invalid because the statutory beneficiaries had not requested a hearing and there was no party represented by the attorney with standing to request a postponement. On March 31, 1993, a memorandum in response to the motion to dismiss was filed, as well as a "Supplemental Request for Hearing" with copies of an attorney retainer agreement between the current attorney and decedent's parents.

The Referee dismissed the request for hearing, reasoning that neither the estate nor the personal representative were entitled to file a request for hearing. The Referee relied on ORS 656.204 and ORS 656.218(4) and (5).

The case of Arturo Barron, 46 Van Natta 2362 (1994), has a similar procedural history. In that case, we vacated the Referee's dismissal order and remanded for further proceedings. In doing so, we disagreed with SAIF's reliance on Trice v. Tektronix, Inc., 104 Or App 461 (1990). We distinguished Trice on the grounds that the Barron case involved an initial injury claim, rather than a continuation of the decedent's claim, and the record in Barron contained an allegation that the decedent had statutory beneficiaries, unlike in Trice. We concluded that the request for hearing satisfied the requirements of ORS 656.218(4), which provides that a person entitled to receive death benefits may file a request for hearing, and ORS 656.319(1)(a), which requires that the request for hearing be filed within 60 days of the denial.

We apply the same analysis in this case. As in Barron, the decedent died before filing an initial injury claim. The hearing request has been filed in response to SAIF's denial of the initial claim for death benefits based on its contention that the decedent's death did not arise out of the course and scope of his employment. In other words, the hearing request is designed to litigate the issue of whether the decedent's death resulted from a compensable injury. In the absence of such a determination, there is no entitlement to compensation, regardless of the number of potential statutory beneficiaries.

Here, as in Barron, and unlike in Trice, the record indicates that the decedent had statutory beneficiaries. In fact, SAIF asserted in its motion to dismiss that "ORS 656.204(6) applies to Mr. Rodriguez-Fernandez, age 19 and unmarried, who has surviving parents in Mexico." Survivor rights are independent and not derivative of the injured worker's rights. Fossum v. SAIF, 289 Or 787 (1980). If found as fact, we would concur with SAIF's assertion in that ORS 656.204(6) provides:

> "If the worker is under the age of 21 years at the time of death and leaves neither widow, widower, nor child, the parents of the worker shall be paid, in a lump sum, an amount equal to $75 per month from the death of the worker until the worker would have become 21 years of age. The parents, if dependents at the time of the accidental injury, are entitled thereafter to compensation as dependents under subsection (5) of this section."

SAIF denied the claim on September 29, 1992, on the basis that the fatality did not arise from the decedent's employment. SAIF issued the denial to the "Estate of Rogue Rodriguez-Fernandez" and addressed it to the decedent's former address. There is no indication that SAIF sent a denial letter to decedent's parents. On October 15, 1992, a request for hearing was made by the "Estate of Rogue Rodriguez-Fernandez, Lucio Fernandez, personal representative."

In light of the subsequent submission of an executed retainer agreement between the current attorney and the decedent's parents, the record supports a conclusion that the attorney who signed the request for hearing filed it on behalf of the decedent's putative beneficiaries. Although the request for hearing shows "claimant's" name/address as "Estate of Rogue Rodriguez-Fernandez, Lucio Fernandez, personal representative," we do not consider that phrase determinative, particularly when that designation was in response to SAIF's denial of fatality benefits issued to the "Estate of Rogue Rodriguez-Fernandez."

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 Referee dismissed this case on the ground that no statutory beneficiary had requested a hearing, no fact finding was made to determine whether there are, in fact, statutory beneficiaries entitled to receive death benefits in the event that the decedent's death is found to be compensable. In light of such circumstances, we find the record incompletely and insufficiently developed to make such a determination. See Velma L. Vetternack, 46 Van Natta 929 (1994) (remanded to determine whether a statutory beneficiary existed to continue the claimant's claim).

Accordingly, we vacate the Referee's order dated November 24, 1993, as reaffirmed and republished on February 16, 1994. This matter is remanded to Referee Michael V. Johnson for the presentation of evidence regarding the issue of whether a statutory beneficiary exists to pursue the hearing request and, if so established, the presentation of evidence regarding the compensability of the claim and any other issue raised by the hearing request. These proceedings may be conducted (separately or in consolidation) in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7).

IT IS SO ORDERED.

November 16, 1994 Cite as 46 Van Natta 2371 (1994)

In the Matter of the Compensation of
MARLIN D. ROSSBACK, Claimant
WCB Case No. 93-11799
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Livesley's order that affirmed an Order on Reconsideration which awarded 42 percent (134.4 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

The only dispute concerns the correct value for adaptability. The Referee found that claimant's adaptability factor was 3 based on the applicable standards which require that the strength of a claimant's at-injury job be based on the strength demands given for that job in the DOT. Based on the DOT's strength description, the Referee found that claimant's job at injury was in the medium strength category.

On review, claimant contends that his job-at-injury actually involved heavy work. He argues that his adaptability factor should be 5 (based on a comparison of the strength of his at-injury job which he contends was heavy and his residual functional capacity which was medium-light). Claimant argues that the standards contained in WCD Admin. Order 93-052 apply to his claim and that those standards do not derive the strength of a claimant's at-injury job from the DOT. We disagree.

The standards contained in WCD Admin. Order 93-052 have expired. See Cornell D. Garrett, 46 Van Natta 340 (1994), aff'd mem Garrett v. Still Water Corporation, 130 Or App 679 (1994). In place of WCD Admin. Order 93-052, the Director has adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed 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 436-35-003(2); Michelle Cadigan, 46 Van Natta 307 (1994).

Here, claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268. Thus, the standards in effect at the time of the March 1, 1993 Determination Order (those contained in WCD Admin. Order 6-1992) apply to claimant's claim. Cornell D. Garrett, supra.

In determining the extent of permanent disability, the adaptability factor is a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual capacity (RFC) at the time of determination. Former OAR 436-35-310(1). Prior strength (physical demand) shall be derived from the strength category assigned int he DOT for the worker's job-at-injury. Former OAR 436-35-270(3)(g).

Here, claimant's job-at-injury was as a log truck driver, DOT 904.683-010. The DOT describes this job as a medium-strength job.

In determining which DOT is most applicable, we consider the record as a whole, including the job duties and the physical demands of the relevant job. Nevertheless, the most applicable DOT determines the strength category. See former OAR 436-35-300(3); 436-35-270(3)(g); Cornell D. Garrett, supra; William L. Knox, 45 Van Natta 854 (1993). Although claimant's testimony is relevant to the determination of which DOT most accurately describes his at-injury job, claimant's testimony may not be relied upon to determine that no DOT description accurately describes his job, and that, consequently, his strength category must be determined without regard to the DOT. Kathyron D. Parsons, 45 Van Natta 954 (1993).

Here, claimant does not contend that another DOT job description more accurately describes his job-at-injury. Rather, claimant contends that his job required him to perform heavy work. Based on the applicable standards, the strength requirement for claimant's job must be determined by the DOT job description. Claimant has not submitted, and we have not found, another DOT job description which more accurately reflects his job than log truck driver, DOT 904.683-010. Accordingly, we agree with the Referee's conclusion that claimant's adaptability factor is 3 (prior strength of medium compared with an RFC of medium light with restrictions yields an adaptability value of 3 under former OAR 436-35-310(3)).

ORDER

The Referee's order dated January 21, 1994 is affirmed.

Board Member Hall specially concurring.

For the following reasons, I offer this concurrence. I am bound by the majority's decision in Michelle Cadigan, 46 Van Natta 307 (1994). Nevertheless, I continue to adhere to the analysis and reasoning expressed in the dissent in Cadigan. The Director's "adaptability" rule (OAR 436-35-310; WCD Admin. Order 93-056) is contrary to the statutory mandate to determine "loss of earning capacity." By granting a zero adaptability value when a worker has returned to "regular" work, that worker is not allowed a value for age, education, and adaptability as required by ORS 656.726(3)(f)(A) and 656.214(5). The historical legal analysis for such a holding is set forth in the Cadigan dissent.

The recent decision by the Court of Appeals in Garrett v. Still Water Corporation, 130 Or App 679 (1994), does not alter my opinion. In Garrett, the court affirmed without opinion the Board's order in Cornell D. Garrett, 46 Van Natta 340 (1994), which concerned which DOT job description was most applicable in rating the claimant's permanent disability under the "standards." Cadigan was cited by the Board's majority in Garrett for the proposition that the "standards" in effect at the time of the Determination Order or Notice of Closure were to be applied under the circumstances in Garrett. While I registered a single sentence dissent in Garrett (simply citing to the dissent in Cadigan), Garrett neither fully addressed nor resolved the issues of law raised by the dissent in Cadigan.

As of this date, I am unaware of any case in which an appellate court has directly addressed those particular issues of law. Consequently, the concerns raised in the Cadigan dissenting opinion remain unanswered.

In the Matter of the Compensation of
ELLEN F. SLAYTON, Claimant
WCB Case No. 93-02791
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's denial of claimant's occupational disease claim for right thumb metacarpal joint degenerative osteoarthritis. In her brief, claimant contends that the Referee improperly closed the record without allowing her an opportunity to depose the treating physician in rebuttal. On review, the issues are compensability and evidence.

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

At the close of the May 25, 1993 hearing, pursuant to claimant's request for an opportunity to present rebuttal evidence, the Referee continued the hearing to admit a deposition of Dr. Casey, treating physician. The Referee recommended deposing Dr. Casey by telephone, as that would be expeditious. (Tr. 16). The parties do not dispute subsequent events.

On June 29, 1993, the employer's attorney wrote to the Referee requesting that the record be closed and alleging that claimant had had sufficient time to schedule the deposition but had not done so. On July 29, 1993, claimant's counsel mailed a notice to Dr. Casey scheduling a deposition for August 31, 1993. Dr. Casey cancelled that deposition.

On November 8, 1993, the Referee notified the parties: "If I am not informed by November 15, 1993 that Dr. Casey's deposition has been scheduled for a particular day I will proceed to issue an Opinion and Order."

On November 18, 1993, the employer's attorney submitted a letter to the Referee.[1] In that letter, the employer's counsel explained that claimant's attorney's secretary had contacted the employer's attorney's secretary on the morning of November 15, 1993 to make arrangements for Dr. Casey's deposition. A mutually satisfactory time could not be arranged. In light of such circumstances, the employer's attorney requested that the record be closed.

On November 30, 1993, claimant's counsel: (1) informed the Referee that Dr. Casey had cancelled the August deposition; (2) described his lack of success in rescheduling a deposition; and (3) requested that the employer "produce" the doctor for cross-examination.

On February 23, 1993, the Referee issued his Opinion and Order. In that order, the Referee noted that the parties disputed who was responsible for ensuring that Dr. Casey be deposed.[2] However, reasoning that his conclusion on the merits would be the same even if he were to exclude the report (submitted by the employer) which gave rise to the request for a deposition, the Referee issued his order without the deposition.

On review, claimant contends that the Referee erred in closing the record without receipt of Dr. Casey's deposition. We disagree.

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[1] Claimant first became aware of this letter when it was attached to the insurer's respondent's brief. Under these circumstances, the letter amounted to an improper ex parte contact with the Referee. See OAR 438-06-045.

[2] In general, we believe that the proponent of the medical report should produce its author for deposition at the opposing party's request, or at least cooperate in obtaining the deposition. In addition, we note that the remedy for failure to comply with the Board's express disclosure requirements may be exclusion of the evidence which gave rise to the deposition request. See OAR 438-07-015(4).

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. OAR 438-06-091(3). Couched in permissive language, the rule contemplates that the exercise of the authority to continue a hearing rests within a Referee's discretion. See Randy L. Kling, 38 Van Natta 1046 (1986). Further, the Referee was not bound by technical or formal rules of procedure, and had statutory authority to conduct the hearing in any manner that would achieve "substantial justice." See ORS 656.283(7).

Here, in continuing the hearing, the Referee expressed the hope that Dr. Casey's deposition could be obtained in an expeditious manner. Nevertheless, when some 6 months had passed since the hearing, the Referee notified the parties that the record would close unless the Referee was informed by November 15, 1993 of the particular date of Dr. Casey's deposition.

The record establishes that the Referee was not informed of the scheduling of such a deposition by November 15, 1993 as expressly specified in his November 8, 1993 letter to the parties. Claimant does not contend that her counsel did not receive that notification or misunderstood its warning. Under these circumstances, we do not find that the Referee abused his discretion by closing the record without a deposition of Dr. Casey and then issuing his Opinion and Order on February 23, 1994. See Ronald D. Hughes, 43 Van Natta 1911 (1991); David F. Bowen, 42 Van Natta 2705 (1990).[3]

Finally, as reasoned by the Referee, we note that claimant's remedy would be exclusion of Dr. Casey's May 10, 1993 report that had been submitted by the employer, which gave rise to claimant's request for an opportunity to depose the doctor. (See Ex. 16). However, we agree with the Referee that exclusion of that report would not change the outcome of this compensability issue.

ORDER

The Referee's order dated February 23, 1994 is affirmed.

[3] The present case is distinguishable from Edward D. Swor, 45 Van Natta 1690 (1993), in which the Board found that the Referee abused his discretion in refusing to allow claimant an opportunity to cross-examine a doctor. Here, the Referee did allow the record to be left open for a deposition.

In the Matter of the Compensation of
DOUGLAS L. TYREE, Claimant
WCB Case No. 93-03679
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On April 22, 1994, we withdrew 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). In addition, based on claimant's unchallenged request, we have conducted our reconsideration of this case in consolidation with WCB Case No. 93-10766. After completing our reconsideration, we replace our prior order with the following order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that he was entitled to additional scheduled permanent disability. We disagree.

The only dispute in this case is whether claimant has established entitlement to an additional 5 percent permanent disability based on a "chronic condition" under former OAR 436-35-010(6). That provision grants a worker 5 percent if the preponderance of the medical evidence establishes that the worker is unable to repetitively use a body part due to a chronic and permanent condition resulting from the compensable injury. Id. 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).

Here, in mid-1992, Dr. Panum, claimant's attending physician, released claimant to modified work with the limitation that claimant could not perform any repetitive tight grasping. (Exs. 14, 27, 30-33). In January 1993, Dr. Panum reported that claimant suffered from "bilateral hand pain without a specific determinable etiology." (Ex. 17). As a result of this condition, Dr. Panum opined that claimant had permanent limitations of no repetitive hand work and no tight grasping using his hands. (Id.)

We generally defer to the opinion of the attending physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We find no persuasive reasons not to defer to opinion of Dr. Panum. Although Dr. Panum did report that claimant's limitations were of unknown etiology, the cause has since been determined. That is, in WCB Case No. 93-10766, we affirmed the Referee's finding that claimant's bilateral wrist syndrome is a part of claimant's compensable claim. Consequently, we conclude that claimant has established entitlement to an additional 5 percent award under former OAR 436-35-010(6).[1]

ORDER

The Referee's order dated June 29, 1993 is modified. In addition to the 2 percent (3 degrees) scheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist) for a total award of 7 percent (10.5 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

[1] We distinguish this case from our decision in Rae L. Holzapfel, 45 Van Natta 1748 (1993). In Holzapfel, supra, the medical evidence did not establish that the claimant was unable to repetitively use her hands, nor was there any medical evidence from which the Board could make such a finding. Id. at 1749. Here, by contrast, Dr. Panum affirmatively stated that claimant had permanent limitations of no repetitive hand work and no tight grasping using his hands. We find this opinion sufficient medical evidence on which to base a chronic condition award.

November 16, 1994 Cite as 46 Van Natta 2375 (1994)

In the Matter of the Compensation of
DOUGLAS L. TYREE, Claimant
WCB Case No. 93-10766
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Livesley's order that: (1) upheld the SAIF Corporation's October 21, 1993 amended denial of claimant's bilateral wrist overuse syndrome; and (2) declined to assess a penalty for SAIF's allegedly unreasonable denial of that condition. Based on claimant's unchallenged request, we have reviewed this case in consolidation with our order on reconsideration in WCB Case No. 93-03679. On review, the issues are compensability and penalties.

We adopt and affirm the Referee's order, with the exception of the second to last full paragraph on page 4 of the Opinion and Order and the second and third paragraphs on page 5 of the Opinion and Order, with the following supplementation.

On July 27, 1992, SAIF accepted claimant's bilateral carpal tunnel syndrome; the same day, SAIF closed the claim without an award of permanent disability benefits. Subsequently, an Order on Reconsideration awarded claimant 2 percent (3 degrees) scheduled permanent disability for loss of use of the right forearm (wrist) related to claimant's decreased right wrist dorsiflexion.

Claimant requested a hearing regarding the Order on Reconsideration. He argued that he was entitled to additional permanent disability compensation based on the recommendation of his treating physician, Dr. Panum, that he not use his hands repetitively at work due to "bilateral hand pain without specific determinable etiology." (Ex. 17).

Meanwhile, after the Order on Reconsideration issued, claimant filed a claim for bilateral wrist overuse syndrome. SAIF denied that claim on the ground that claimant's "overuse syndrome" was the same as the previously accepted carpal tunnel syndrome claim. Subsequently, SAIF amended its denial to state that the benefits to which claimant was entitled for his current "overuse syndrome" were being paid under the accepted claim.

Thereafter, claimant requested a hearing regarding SAIF's amended denial, thus giving rise to the present case. At hearing, claimant argued that his overuse syndrome was a new condition, separate from the carpal tunnel syndrome that SAIF had accepted in WCB Case No. 93-03679.

To prevail on a "new" condition theory, claimant must establish that his current "overuse syndrome" is different from his previously accepted carpal tunnel condition. See Christopher H. Peppler, 44 Van Natta 856, 857 (1992). We agree with the Referee that there is insufficient evidence that what claimant now suffers from is different from the condition that SAIF accepted in July 1992. See Irene Jensen, 42 Van Natta 2838 (1990) ("fibromyalgia" claim precluded by prior litigation of "back strain" claim because, although "fibromyalgia" was new diagnosis, that condition was the same as the previously litigated condition).

Claimant argues that Dr. Panum's opinion that he suffers from "bilateral hand pain without specific determinable etiology" is sufficient to establish a new condition. We disagree. In view of claimant's history of atypical upper extremity pain both before and after SAIF's accepted claimant's bilateral carpal tunnel syndrome, and the fact that Dr. Panum did not expressly state that claimant's current condition was different from his accepted condition, we conclude that claimant has failed to establish that his current overuse syndrome is a "new" condition. Instead, based on the position taken by SAIF, and based on the evidence in this record, we find that the symptom complex diagnosed by Dr. Panum as "overuse syndrome" was previously accepted by SAIF within the symptom complex SAIF accepted under the diagnosis of bilateral carpal tunnel syndrome.

Claimant also contends that he is entitled to more permanent disability benefits than that previously awarded and affirmed by the Referee in WCB Case No. 93-03679 and that SAIF should be assessed a penalty for its allegedly unreasonable resistance to the payment of additional permanent disability compensation. Inasmuch as these issues were not raised before the Referee in this case, we decline to consider them on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Finally, since we have found that SAIF's amended denial was appropriate, it likewise follows that we do not consider its conduct to have been unreasonable. Consequently, we conclude that neither penalties nor attorney fees are warranted.

ORDER

The Referee's order dated January 6, 1994 is affirmed.

In the Matter of the Compensation of
COLIN C. BRADBURY, Claimant
WCB Case No. 93-14075
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Carter & Cliff, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Thye's order which found that he was not a subject worker. On review, the issue is subjectivity.

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

The Referee found that claimant was not a "subject worker" when he fell from a ladder and sustained severe injuries while stripping paint and sanding the exterior of the employer's residence. The Referee applied ORS 656.027(2) in making his subjectivity determination, reasoning that, because claimant was employed in the maintenance and repair of a "private home," he was excluded from workers' compensation coverage.[1] On review, claimant cites Fincham v. Wendt, 59 Or App 416 (1982) in support of his argument that he was injured on the premises of a commercial operation rather than a "private home."

In Fincham, the claimant was injured while working on a cold storage room in a building located on a "hobby farm." The building was used to store tractors, tools, farm equipment, and fruit intended for sale. Inasmuch as the cold storage room was directly related to fruit sales, the court concluded that the claimant was engaged in work on the premises of a farm operation rather than on an extension of a private home. 59 Or App at 420. The court also likened the employer to a producer of goods rather than a consumer of them like an ordinary householder. Id. at 423. Thus, the court reasoned that the claimant's injury occurred while engaged in the furtherance of a commercial operation. The court, therefore, found that, because the claimant was not injured while working about a "private home," he was a subject worker. ORS 656.027(2).

We find Fincham distinguishable and conclude that claimant was injured while performing maintenance or repair on a "private home." Thus, claimant was not a subject worker at the time of injury. We reach this conclusion for the following reasons.

The employer hired claimant to work at his private residence. Unlike the employer in Fincham, who was a producer of goods, the employer here, who is semi-retired, is a consumer of services, such as those that claimant provided. His home is used as a residence. (Tr. 46). There is no evidence that the employer intended to sell or rent the property. In fact, he testified that he would never consider doing so. (Tr. 60). Although the employer managed his investments, including seven rental properties, from his residence, he has not claimed any portion of his residence as an office for tax purposes. Cf. Lorenzo Perez, 42 Van Natta 1127, 1129 (1990) (where the employer filed federal tax returns indicating that residence was operated as a farm business, residence found not to be a "private home"; exemption of ORS 656.027(2) not applicable.).

In addition, the only work claimant ever performed for the employer was at the residence. (Tr. 16). The employer never told claimant that he would ever work on his rental properties. (Trs. 18, 48). The employer's residence is not open to the public as a business or office. (Tr. 61). There is no evidence that the improvement of the employer's home contributed in any manner to the operation of the employer's rental properties or management of his other investments.

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[1] ORS 656.027(2) includes as a non-subject worker:

"A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker."

Although the employer does write checks related to the operation of his rental properties bearing the address of his residence, we find that the great weight of the evidence leads to the conclusion that claimant was injured while performing work "in or about the private home of the person employing the worker." ORS 656.027(2). The Referee correctly determined that claimant was not a subject worker.

ORDER

The Referee's order dated April 11, 1994 is affirmed.

In the Matter of the Compensation of
ANCIL R. HONEYWELL, Claimant
WCB Case Nos. 93-11939 & 93-11692
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

United Employers Insurance Company (United), on behalf of Food Value Markets, requests review of those portions of Referee Brazeau's order which: (1) set aside its denial of claimant's low back aggravation claim; (2) upheld the SAIF Corporation's denial, on behalf of Melody Hills Dairy, of claimant's "new injury" claim for the same condition; and (3) awarded a $3,000 attorney fee payable by United. Claimant cross-requests review of those portions of the order that set aside United's denial and upheld SAIF's denial. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

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

The Referee concluded that United, which was responsible for claimant's low back condition resulting from a 1986 injury, had failed to sustain its burden of proving that claimant had suffered a "new injury" on April 20, 1993 while employed by SAIF's insured, Melody Hills Dairy. See ORS 656.308(1); Mark A. Newkirk, 46 Van Natta 1227, 1230 (1994). Reasoning that the medical opinion of Dr. Buza was insufficient to establish that the April 20, 1993 incident was the "major contributing cause" of claimant's disability and need for medical treatment, the Referee set aside United's denial/disclaimer of responsibility. See SAIF v. Drews, 318 Or 1 (1993).

Based on our de novo review of the medical evidence from Dr. Buza, we find that his opinion is contradictory and unclear. Although Dr. Buza opined prior to his deposition that the April 1993 incident was the major contributing cause of claimant's need for medical treatment, his subsequent testimony indicates that he was uncertain as to the major contributing cause of claimant's current condition. (See Ex. 98-53). Inasmuch as United has the burden of proof, we construe any ambiguity or uncertainty in Dr. Buza's testimony against United. We, accordingly, agree with the Referee that Dr. Buza's medical opinion is insufficient to shift responsibility for claimant's current low back condition to SAIF. Therefore, responsibility lies with United Employers. See ORS 656.308(1).

Attorney Fees

Both United and SAIF conceded compensability at hearing. The Referee assessed an attorney fee against United, which it contends was an error. We find that claimant's counsel is entitled to assessed attorney fees under ORS 656.386(1)for services in obtaining rescission of both compensability denials without a hearing.

United's December 13, 1993 denial/disclaimer of responsibility noted that a Claim Disposition Agreement had been executed relative to claimant's 1986 injury claim. It stated that "indemnity benefits" were being denied. Also, the denial letter recited that responsibility was also being denied and that SAIF might be responsible for claimant's condition. Claimant was advised to file a claim with SAIF within 60 days. See ORS 656.308(2).

However, no paying agent was requested and the denial letter stated that it was a "Denial of Your Claim For Benefits." Compensability was not conceded. The denial further included "notice of hearing" provisions. Under these circumstances, we find that United's December 13, 1993 denial created an issue concerning the compensability of claimant's low back condition. See Linda K. Ennis, 46 Van Natta 1142, 1143 (1994) (compensability issue created when disclaimer/denial contained notice of hearing provisions, recited that it was a denial of a claim for benefits and stated that a paying agent had not been requested); but cf. James McGougan, 46 Van Natta 1639 (1994) (denial did not raise compensability issue when compensability was specifically conceded and denial letter stated that a paying agent would be requested). Claimant's compensation was at risk until compensability was conceded at hearing.

On October 14, 1993, SAIF had issued a "disclaimer of responsibility and claim denial." Like United's denial, SAIF's denial/disclaimer also stated that it was a denial of a claim for benefits and contained notice of hearing provisions consistent with a denial of compensation. Moreover, it specifically stated that a paying agent had not been requested. Given the above, we find that SAIF's October 14, 1993 denial and disclaimer also raised an issue concerning compensability of the claim and similarly kept claimant's compensation at risk. Linda K. Ennis, supra.

Under these circumstances, we find that claimant's attorney was instrumental in obtaining concessions of compensability from United and SAIF. We conclude, therefore, that claimant is entitled to a carrier-paid attorney fee for his counsel's efforts in obtaining the rescission of the compensability portions of United's and SAIF's denials prior to hearing. See Gates v. Liberty Northwest Ins. Corp., 131 Or App 164 (1994); Penny L. Hamrick, 46 Van Natta 14 (1994). We further conclude that counsel is entitled to a separate attorney fee for each rescission. See John W. Wantowski, 46 Van Natta 1158 (1994); 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 $750 is a reasonable assessed attorney fee for claimant's counsel's services concerning the rescission of the compensability portion of SAIF's denial. However, inasmuch as the Referee has already awarded claimant's counsel a $3,000 assessed fee for his services in setting aside United's denial (and United does not challenge the amount of the attorney fee award), we conclude that this is a reasonable fee for counsel's pre-hearing and hearing services concerning the compensability portion of United's denial. 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.

Claimant is also entitled to a fee under ORS 656.382(2). That statute authorizes attorney fees when claimant's right to compensation is at risk of disallowance or reduction. See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). While compensability was not an issue on review or addressed in the Referee's order, United's appeal did put claimant's compensation at risk because of a potential reduction of claimant's temporary disability rate had United prevailed on review. See International Paper Co. v. Riggs, 114 Or App 203, 206 (1992); Ollie D. Wigger, 43 Van Natta 261 (1991).

Claimant's form 801 indicates that his hourly rate for employment for United's insured was $13.26 per hour and that he worked 48 hours per week. On the other hand, claimant earned $1,700 a month working at SAIF's insured, Melody Hills. Since claimant's temporary disability rate under the SAIF claim is lower than under the United claim, claimant's compensation is at risk of reduction as a result of United's appeal. Under such circumstances, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). Cf. Bonnie A. Stafford, 46 Van Natta 1452, on recon 46 Van Natta 1540 (1994) (claimant not entitled to assessed fee under ORS 656.382(2) where temporary disability rate not at risk of reduction because of an insurer's appeal of responsibility determination).

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 $500, to be paid by United Employers. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and respondent's brief), the complexity of the issues, and the value of the interest involved. We have also considered that claimant's arguments as to the responsible carrier were unsuccessful. See International Paper Co. v. Riggs, supra, at 207.

ORDER

The Referee's order dated March 30, 1994 is modified in part and affirmed in part. For claimant's counsel's efforts in obtaining the withdrawal of the compensability portion of SAIF's denial without a hearing, claimant's attorney is awarded a $750 attorney fee, payable by SAIF. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is also awarded an assessed attorney fee of $500, payable by United Employers.

November 18, 1994 Cite as 46 Van Natta 2380 (1994)

In the Matter of the Compensation of
MYKEL B. HORN, Claimant
WCB Case No. 93-13857
ORDER ON REVIEW
Montgomery W. Cobb, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Lipton's order that upheld the SAIF Corporation's "de facto" denial, on behalf of the noncomplying employer (NCE), of claimant's left shoulder rotator cuff condition on the ground that claimant was barred by claim preclusion from litigating the compensability of that condition. On review, the issues are res judicata, compensability 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

Claim Preclusion/Compensability

The primary issue in this case is the compensability of claimant's left shoulder rotator cuff condition. Claimant's theory is that that condition is a compensable consequence of a right elbow condition that SAIF accepted pursuant to a prior referee's order. (See Ex. 6). See ORS 656.005(7)(a)(A). In that order, the prior referee also addressed the compensability of claimant's left shoulder condition as to two other employers. The Referee in this matter concluded that, because the compensability of the left shoulder rotator cuff condition as to SAIF and the NCE could have been joined in the first action, claimant was barred by claim preclusion from litigating that claim now. We disagree.

SAIF makes several arguments in support of the application of claim preclusion to this case. We need not address those arguments, because we agree with claimant's assertion that, as to SAIF and the NCE, the compensability of the left shoulder rotator cuff condition was not ripe at the time of the prior hearing. At that time, SAIF had neither denied the claim, nor had the time within which SAIF had to accept or deny the claim expired. See ORS 656.262(6); see also Robert F. Curtis, 46 Van Natta 1118 (1994) (Board declined to address claim preclusion argument in case where premature closure issue was not ripe prior to the claimant's request for hearing regarding a Determination Order and Order on Reconsideration).[1] Accordingly, we reverse the Referee's conclusion that claimant's left shoulder rotator cuff claim is barred by claim preclusion. We turn to the merits of the claim.

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[1] The parties do not dispute that, at the time of the prior hearing, SAIF had not denied claimant's left shoulder rotator cuff claim, or that the time within which SAIF had to accept or deny the claim had not expired.

The only evidence regarding the compensability of claimant's left shoulder rotator cuff is a medical report from treating physician, Dr. Beck. In that report, Dr. Beck concluded that the major contributing cause of claimant's current left shoulder problems was the compensatory overuse of the left shoulder in conjunction with the rehabilitation and reduced use of the right elbow, related to claimant's accepted right elbow claim. (Ex. 4A-1). In the absence of any controverting evidence, and in view of Dr. Beck's status as the treating physician, we conclude that claimant has established the compensability of his left shoulder rotator cuff as a consequence of his accepted right elbow condition under ORS 656.005(7)(a)(A).

Penalties

In his opening brief, claimant asserts that SAIF should be assessed a penalty for its improper claim processing. SAIF argues that, in light of claimant's withdrawal of the penalty issue at hearing (Tr. 3; see Opinion and Order at 1), claimant may not pursue that issue on Board review. We agree. Janet K. Mally, 38 Van Natta 1496 (1986). Accordingly, we affirm the Referee's decision declining to assess a penalty against SAIF.

Attorney Fees

Claimant is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on review regarding the compensability/claim preclusion issue is $3,500, payable by SAIF.[2] In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, counsel's statement of services on review, SAIF's response to the statement of services, and the hearing record), the complexity of the issues, the value of the interest involved and the risk that claimant's counsels might go uncompensated. Claimant is not entitled to a fee for services on review regarding the penalty issue.

ORDER

The Referee's order dated March 3, 1994 is reversed in part an affirmed in part. The SAIF Corporation's "de facto" denial of claimant's left shoulder rotator cuff condition 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 an assessed fee for services at hearing and on review of $3,500, payable by SAIF.

[2] We note that claimant was represented by one attorney at hearing and another on review. Thus, it would appear that each attorney is entitled to a share of the attorney fee award. Nevertheless, SAIF is required to pay the entire award to claimant's appellate counsel, claimant's current attorney of record. The manner in which the fee is shared by claimant's current and former counsels is a matter between the two of them, not this forum. Gabriel Zapata, 46 Van Natta 403 (1994).

November 18, 1994 Cite as 46 Van Natta 2381 (1994)

In the Matter of the Compensation of
SUSAN K. MARLNEE, Claimant
WCB Case No. 93-12153
SECOND ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Hoffman, et al., Defense Attorneys

On November 10, 1994, we withdrew our October 14, 1994 Order on Reconsideration, which had republished our September 20, 1994 Order on Review that: (1) reduced claimant's scheduled permanent disability award for loss of use or function of the left forearm (wrist) from 28 percent (42 degrees), as awarded by a Referee's order, to 24 percent (36 degrees) (the award previously granted by an Order on Reconsideration); (2) affirmed the Referee's attorney fee award under ORS 656.382(2); and affirmed the Referee's penalty assessment under ORS 656.268(4)(g). We took this action to retain jurisdiction to consider the parties' proposed stipulation. Having received the parties' agreement, we proceed with our reconsideration.

The proposed "Stipulation and Order of Dismissal," is designed to fully compromise the parties' disputes, in lieu of all prior orders. Specifically, the parties agree that: (1) claimant's scheduled permanent disability award is 24 percent (36 degrees); and (2) claimant's attorney shall receive 10 percent of the aforementioned award as an "out-of-compensation" fee, as well as the $1,000 carrier-paid attorney fee granted by the Referee under ORS 656.382(2).

Finally, the parties reach the following resolution regarding the penalty issue. They acknowledge that there are several cases presently pending judicial review which address the issue of whether a penalty under ORS 656.268(4)(g) is appropriate when an increased permanent disability award is granted by an Order on Reconsideration based on a medical arbiter's report. The parties agree that their penalty dispute will be resolved by the court's ultimate holding concerning that issue. In other words, if the court holds that such circumstances do not warrant a penalty assessment, the employer will not be required to pay the penalty. Conversely, if the court holds that such circumstances do warrant a penalty assessment, the employer will be required to pay the penalty ($2,745.81).

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of all prior orders. In granting this approval, we have concluded that, notwithstanding the contingent nature of the stipulation, claimant's entitlement to a penalty under ORS 656.268(4)(g) as a result of the ultimate determination in the cases cited in the stipulation will be readily ascertainable. See Shirley A. Roth, 43 Van Natta 1802 (1991).

Accordingly, on reconsideration, this matter is dismissed.

IT IS SO ORDERED.

November 18, 1994 Cite as 46 Van Natta 2382 (1994)

In the Matter of the Compensation of
LINDA J. MORSS, Claimant
WCB Case No. 93-02671
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Bethlahmy's order that set aside its denial of claimant's right knee injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

The employer and its landlord signed a lease for office and warehouse space. (Ex. 2A). The employer paid rent for the premises; it also paid a fee proportional to its leased space for its share of the landlord's costs for managing, maintaining and operating common areas. (Ex. 2A-1, -6). Under the lease agreement, the landlord agreed to maintain the common areas in good condition at all times. (Ex. 2A-4). The common areas included facilities outside the individual leased premises, including parking areas and roads. (Ex. 2A-6). The employer was given a nonexclusive right to the reasonable use and enjoyment of the common areas and parking in common with other tenants or the landlord, subject to the landlord's rights of common area management, maintenance and costs. (Ex. 2A-7).

The lease also provided,

> "Except in an emergency creating immediate risk of personal injury or property damage, neither party may perform repairs which are the obligation of the other party and charge the other party for the resulting expenses unless at least thirty (30) days before work is commenced the defaulting parties are given notice in writing which outlines with reasonable particularity the repairs required and such party fails within that time to initiate such repairs in good faith." (Ex. 2A-14).

The employer was given three reserved parking spaces immediately adjacent to the sidewalk in front of its premises. (Ex. 2A-15, -16, -20). These parking spaces were used primarily by the employer's sales staff, although other employees parked in them when space was available. (Tr. 9, 12, 20; Ex. F). A driveway giving access to the employer's warehouse was located immediately to the left of the parking spaces. (Exs. D, E, 9 and 10). This driveway was used exclusively by the employer for its service trucks to enter and leave the warehouse. (Tr. 36, 37).

On or about 8:30 a.m. on December 23, 1992, while on her way to work, claimant injured her right knee when she slipped and fell on the blacktop outside the employer's premises, between the driveway to the employer's warehouse and the first designated parking space. The day was cold and icy and the blacktop was slick. Claimant had parked in front of the premises to unload food she had brought, with the employer's permission, for an office Christmas lunch. The employer knew of and did not object to claimant's bringing food to work for the lunch. (Ex. 8-8 and Tr. 43).

CONCLUSIONS OF LAW AND OPINION

Relying on Boyd v. SAIF, 115 Or App 241 (1992), the Referee reasoned that, because the employer exercised control over the premises where claimant fell while on her way to work, claimant's right knee injury arose out of and in the course of employment. On review, SAIF argues that the employer did not exercise control over the area where claimant fell. We disagree.

Subsequent to the Referee's order, the Supreme Court issued its decision in Norpac Foods v. Gilmore, 318 Or 363 (1994). Citing Clark v. U.S. Plywood, 288 Or 255, 260 (1980), the 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 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, 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. Both factors must be evaluated in determining work connection; neither is dispositive. Phil A. Livesley Co. v. Russ, 296 Or 25 (1983).

We begin with the "in the course of" element of the work-connection test. There is no dispute that this is a "parking lot" case. Therefore, the relevant inquiry is whether the employer exercised at least partial control over the area where claimant fell. See Montgomery Ward v. Malinen, 71 Or App 457, 461 (1984). In Henderson v. S.D. Deacon Corp., 127 Or App 333, 337 (1994), the court concluded that sufficient employer control was established by a lease giving the employer a nonexclusive right to use an elevator where the claimant was injured, the right to require repairs of the elevator and requiring that the employer pay a share of operating expenses.

Similarly, here, the lease between the employer and the landlord provided that the landlord was responsible for maintenance, management and operation of the common areas, including parking areas and roads. However, the lease gave the employer the nonexclusive right to use the common areas and the employer paid a portion of the maintenance and management costs of the common areas. Moreover, the lease provided that, after 30 days' written notice to the other party describing repairs needed, except in an emergency, either the landlord or the employer could make repairs if the other party failed or refused to do so and could recoup expenses from the non-performing party.

We conclude that, as did the court in Henderson, the lease is evidence that the employer exercised at least some control over the area where claimant was injured. See also Walter R. Adams, 46 Van Natta 1742 (1994) (the employer had control of the area of injury where the lease established that the landlord for whom the employer was the exclusive managing agent was responsible for maintaining the area of injury). This conclusion is strengthened by evidence that the area where claimant fell was used exclusively by the employer and its employees.

Our conclusion is further strengthened by the fact that the lease allowed either party to make repairs without 30-days' notice "in an emergency creating immediate risk of personal injury or property

damage." (See Ex. 2A-14). Although that language does not expressly obligate the parties to repair emergency defects that create an immediate risk of personal injury or property damage, we conclude that it nevertheless is another indication of the employer's control over the premises. That slick or icy pavement plainly falls within the emergency defects contemplated by the lease lends additional force to our conclusion that the employer had control over the area where claimant fell.

We conclude that, under the specific circumstances here, there was a sufficient connection between the employer and the area where the injury occurred to establish that claimant's injury occurred in the course of her employment.

We turn to the "arising out of" element of the work-connection test. This element measures the causal connection between the injury and the worker's employment. 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 exercised some control. Ronald R. Nelson, 46 Van Natta 1094 (1994) (claimant's injury after falling on rough pavement on employer's driveway held to arise out of claimant's employment); see Linda N. Kief, 46 Van Natta 2290 (1994) (claimant's injury "arose out of" employment when injury was caused by accumulation of ice on employer's parking lot); compare William F. Gilmore, 46 Van Natta 999 (1994) (order on remand) (claimant's knee injury that did not result from any hazard attributable to employer's parking lot held to not arise out of claimant's employment).

Here, the evidence establishes, and the parties do not dispute, that, on the day that claimant fell, the weather was cold and icy, and the pavement slick. Because the record establishes that claimant's fall was caused by slick pavement over which the employer exercised some control, we conclude that there is a sufficient causal connection between claimant's employment and the injury to establish that claimant's injury "arose out of" her employment.[1] Ronald R. Nelson, supra; Linda N. Kief, supra.

For these reasons, we conclude that claimant has established that her injury arose out of and in the course of her employment. Accordingly, we affirm the Referee's decision setting aside the SAIF Corporation's denial of claimant's right knee injury claim.

Claimant's counsel is entitled to an attorney 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 assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 29, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

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[1] In reaching this conclusion, we note our decision in Denise C. Smith, 46 Van Natta 783 (1994). In that case, we held that a claimant's injury sustained on an employer-controlled parking lot did not "arise out of" her employment because the claimant was on the lot solely for her husband's convenience and because there was no evidence that the employer acquiesced in the claimant's use of the lot. In Smith, we also found that claimant had a "purely personal motive" in being on the parking lot where she fell. Id. at 784.

Here, in contrast, the employer acquiesced in claimant's plans for the office Christmas lunch. Although claimant may have instigated the lunch plans, we conclude that, in light of the employer's acquiescence in those plans, and the fact that the lunch was for the benefit of all office personnel, claimant's motive in parking where she did was not purely personal. Under the circumstances, we do not find claimant's pursuit of the lunch plans sufficient to break the link between her injury and her employment.

In the Matter of the Compensation of
ROBERTO RODRIGUEZ, Claimant
WCB Case No. 93-06124
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Claimant requests reconsideration of our October 21, 1994 Order on Reconsideration that reduced his award of unscheduled permanent disability for a low back condition to 29 percent (92.8 degrees) from 31 percent (99.2 degrees) (pursuant to an Order on Reconsideration award which had been affirmed by a Referee's order). Seeking clarification of his counsel's attorney fee award, claimant requests reconsideration.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY H. SMITH, Claimant
WCB Case No. 93-11336
ORDER ON REVIEW
Galton, Scott, et al., Claimant Attorneys
VavRosky, 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 denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

When claimant was a child, he had tuberculosis, which caused spontaneous fusion of some lumbar vertebrae and the development of spinal stenosis. In January 1993, claimant experienced low back pain after lifting a large person while working as a firefighter. Claimant's back pain eventually ceased while he was convalescing from knee surgery. In May 1993, after playing golf, claimant again had low back pain as well as left leg pain and, in June 1993, sought treatment for his symptoms. In August 1993, claimant underwent back surgery.

The Referee concluded that claimant failed to prove that his need for treatment and/or disability was compensable. On review, claimant challenges that conclusion, asserting that he proved compensability under U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), by showing that the January 1993 lifting incident precipitated his low back symptoms.

The medical evidence shows that claimant sustained an injury from the January 1993 lifting incident and that such injury combined with his preexisting spinal stenosis to result in disability or the need for treatment. (Exs. 12-5, 20-2). Thus, in order to prevail, claimant must prove that the lifting incident was the major contributing cause of his disability or need for treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590 (1993).

We agree with the Referee that claimant failed to carry his burden. According to claimant's treating neurosurgeon, Dr. Mason, and examining physicians Dr. Marble, orthopedic surgeon, and Dr. Reimer, neurologist, claimant's preexisting spinal stenosis was the major contributing cause of his need for treatment and the January 1993 lifting incident was a minor factor. (Exs. 12-7, 20-2, 21-7, 21-14).

Our conclusion is not affected by U-Haul of Oregon v. Burtis, supra. The only evidence supporting application of Burtis is Dr. Mason's agreement, during a deposition, that, if claimant's symptoms began at the time of the January 1993 lifting event, he would consider such incident the major contributing cause of claimant's pain. (Ex. 21-26). However, Dr. Mason later clarified that such an opinion would be based on a history of continuous symptoms following the January 1993 event until claimant sought treatment in June 1993. (Id. at 28). Since claimant's low back symptoms resolved in March 1993, when he was recovering from knee surgery, Dr. Mason indicated that it was just as likely that the strain had resolved by March 1993 and that claimant's golfing activities which preceded the reoccurrence of pain in May 1993 was responsible for the onset of symptoms. (Id. at 29-30).

Based on such evidence, we also agree with the Referee that claimant failed to prove that the January 1993 lifting incident caused claimant's preexisting spinal stenosis to become symptomatic. Thus, we find this case distinguishable from Burtis.

ORDER

The Referee's order dated April 28, 1994 is affirmed.

November 18, 1994 Cite as 46 Van Natta 2386 (1994)

In the Matter of the Compensation of
ROY R. STOLTENBURG, Claimant
WCB Case No. 94-00294
ORDER ON REVIEW
Huffman, Zenger, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Referee Podnar's order which: (1) set aside its "denial" of claimant's medical services claim for low back surgery; and (2) awarded claimant's counsel an assessed attorney fee for his efforts in setting aside the "denial." In his brief, claimant requests an attorney fee award under ORS 656.382(1) and (2). On review, the issues are medical services and attorney fees.

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

On June 15, 1992, claimant's treating physician, Dr. Nash, requested authorization for proposed decompression surgery at L3-L4. SAIF referred the medical services claim for Director review in November 1992. This resulted in a February 3, 1993 Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, finding that the proposed surgery was not reasonable and necessary. Claimant requested review of the Director's order before the Hearings Division. See ORS 656.327(1)(b). SAIF has never issued a formal denial of claimant's medical services claim.

The hearing convened on April 6, 1994. At the hearing, SAIF contested the compensability of claimant's surgery claim. (Tr. 13). Conducting a de novo review, the Referee found that the surgery, which had been performed on February 10, 1994, was reasonable and necessary. The Referee, therefore, set aside SAIF's "denial." In addition, the Referee awarded an attorney fee for claimant's counsel's efforts in setting aside the "denial."

On review, SAIF contends that the Referee lacked "jurisdiction" to review the medical services issue. We disagree.

It is now well-settled that jurisdiction over questions concerning proposed medical treatment resides exclusively with the Board. See Martin v. City of Albany, 320 Or 175, 188 (1994); Niccum v. Southcoast Lumber Co., 320 Or 189 (1994). In light of this, the Director lacked jurisdiction over the issue of the proposed surgery. Thus, the February 3, 1993 Director's order was null and void. Moreover, after performance of the surgery, there was no subsequent request for Director review.

Accordingly, the Referee had jurisdiction to review the appropriateness of claimant's surgery. See Meyers v. Darigold, 123 Or App 217 (1993). The Referee correctly conducted a de novo review of the record in determining whether the surgery was reasonable and necessary. For the reasons cited in the Referee's order, we agree that the surgery was reasonable and necessary.

SAIF contests the Referee's attorney fee award, even though conceding that, under Gwen Jackson, 46 Van Natta 822 (1994), claimant would be entitled to an attorney fee under ORS 656.386(1) for reversing a denial of a medical services claim. SAIF, however, asserts that SAIF v. Allen, 124 Or App 183 (1993), should preclude an award of an attorney fee under ORS 656.386(1) where causation is not at issue.

Subsequent to the Referee's order, the Supreme Court reversed the Court of Appeals' decision in Allen. SAIF v. Allen, 320 Or 192 (1994). The Court held that a claim for medical benefits is a "claim for compensation" within the meaning of ORS 656.386(1). Id. at 203. Recognizing the importance to the claim adjudication process of a carrier's timely compliance with the notice of claim acceptance or denial requirements of ORS 656.262(6), the Court held that the Board had not erred in concluding that the carrier's conduct (its failure to accept or deny the claim within 90 days and its contention that the medical bills had been timely paid) constituted a denial of the claim that was not confined to the issue of the amount of compensation or the extent of disability. Id. at 207. Since the carrier did not contend that the claimant's counsel had not been instrumental in obtaining payment of the medical bill, the Allen court concluded that ORS 656.386(1) was applicable.

In light of Allen, we conclude that claimant's claim for medical benefits (surgery) was a "claim for compensation" under ORS 656.386(1). Furthermore, we also conclude that SAIF's conduct (its failure to accept claimant's surgery claim within 90 days, as well as its objection to the compensability of the medical service claim) constitute a "de facto" denial. Accordingly, we conclude that claimant is entitled to an assessed fee under ORS 656.386(1) for prevailing against SAIF's "de facto" denial of claimant's surgery claim.

SAIF contends that it did not deny claimant's surgery, but merely submitted claimant's request to the Director for a determination of whether surgery was reasonable and necessary. It cites Charles E. Trento, 46 Van Natta 1502 (1994), in which the Board held that SAIF's recommendation that proposed surgery for a pre-1966 injury be disallowed, did not constitute a denial.

However, we find Trento distinguishable. In Trento, the critical factor in our determination that SAIF had not "denied" claimant's surgery request was the Board's exclusive jurisdiction over medical service claims in connection with pre-1966 injuries. See ORS 656.278(1)(b). The Board's exclusive jurisdiction precluded SAIF from "denying" medical services in a pre-1966 injury claim and limited SAIF's role in claim processing to merely making a recommendation. 46 Van Natta at 1504.

In this case, however, SAIF's role in processing the surgery claim is not limited as it was in Trento. Based on the reasoning expressed in Martin and Jefferson, the Department plays no role in medical services disputes regarding proposed treatment. Original jurisdiction over such disputes resides with the Board and the Hearings Division. Moreover, since no party wished Director review of the surgery dispute before jurisdiction had attached to the Hearings Division, the Director likewise lacked authority over the surgery question. See Meyers v. Darigold, supra.

Therefore, SAIF's claim processing duty is not limited to referring disputed medical services claims to the Director. Inasmuch as SAIF appeared at hearing to contest the reasonableness and necessity of claimant's surgery, and since there is no evidence that SAIF ever paid for claimant's surgery, we find that SAIF's conduct constituted a decision denying a claim for compensation. See SAIF v. Allen, supra; Gwen Jackson, supra. Accordingly, we conclude that the Referee correctly awarded an attorney fee under ORS 656.386(1). SAIF v. Allen, supra.

Finally, claimant requests an attorney fee pursuant to ORS 656.382(1). Inasmuch as claimant did not raise the issue of unreasonable resistance to the payment of compensation at hearing, we will not consider the issue for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, even if we could consider the issue, we would not consider SAIF's conduct to have been unreasonable.

Claimant's counsel is entitled, however, to attorney fees for services on review concerning the surgery 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 assessed attorney fee for claimant's counsel's services on review is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee award for services on review devoted to the attorney fee and penalty issues.

ORDER

The Referee's order dated April 25, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $750, to be paid by SAIF.

In the Matter of the Compensation of
GENE T. BURR, Claimant
WCB Case No. 93-00776
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Nichols' order that upheld the self-insured employer's denial of claimant's occupational disease claim for left ear hearing loss. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of facts. In addition, we briefly summarize and supplement the pertinent findings.

Claimant has worked in the employer's pulp/paper mill since 1962. A 1962 pre-employment audiogram indicated evidence of prior high frequency hearing loss in the left ear.

Claimant has worn hearing protection regularly since 1978. Between April 1979 and August 1992, claimant worked as a caustic operator. From August 1992 to the present, claimant has worked as a pulp operator. Since 1976, both the caustic operator and pulp operator jobs have been performed primarily from inside sound control booths. When claimant goes outside the control booth, he wears hearing protection.

The employer has performed periodic audiometric testing since 1962. Claimant has either used hearing protection or worked in a control booth since 1978. He sought medical attention after he was advised in December 1986 that a routine audiogram revealed decreased hearing in the left ear. Claimant's hearing loss has been relatively stable since 1987.

CONCLUSIONS OF LAW AND OPINION

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

In order to establish an occupational disease claim for hearing loss, claimant must prove that his exposure to noise at work was the major contributing cause of his hearing loss or its worsening. ORS 656.802(1)(c); Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991).

On review, claimant contends that the Referee should have relied on the opinion of new treating physician Stevens, as supported by examining physician Hiatt, and prior treating physician Kauffman. For the following reasons, we disagree.

Dr. Stevens examined claimant in March 1993. Stevens opined that claimant has progressive neurosensory hearing loss due in major part to noise exposure at work. Yet, claimant testified that he has worn hearing protection regularly since 1978 and has worked primarily (90 percent of the time) inside sound control booths since 1979. That information, along with decibel levels in the employer's facility, was provided to Dr. Stevens at his post-hearing deposition.

Dr. Stevens agreed that in the "ideal situation" described, the noise level "isn't bad." Dr. Stevens noted, however, that based on his general knowledge of the industry and information from other patients, he believes that when mill workers leave the control booths to go out onto the floor to repair machinery, they are exposed to injurious noise levels. Dr. Stevens testified, therefore, that "by looking at the serial audiograms and not just the ideal situation of [claimant's] theoretical work environment, but looking at what's actually happened to [claimant's] ears, . . . the high frequency component of [claimant's] hearing loss is very clearly [due to] work noise exposure."

Unfortunately, Dr. Stevens acknowledges that he simply did not know critical information. For example, Dr. Stevens could not recall at what decibel level hearing damage occurs. When queried if he had asked claimant about the sound control booths, or the percentage of time he worked inside the control booths, or the percentage of time spent in certain areas of the plant, or specific work exposures, Dr. Stevens replied "No" to each question. When asked if his conclusion that mill workers on the floor are exposed to injurious noise levels was based on any information supplied by claimant, Dr. Stevens replied that it was not. When asked if he had toured the employer's facility, Dr. Stevens replied that he had not. When asked if he had inquired of claimant what type of hearing protection claimant used or whether claimant wore hearing protection when he was out of the control booth, Dr. Stevens again replied that he had not. Under the circumstances, we are unable to find Dr. Stevens' opinion persuasive.

Finally, Dr. Hiatt's opinion is similarly flawed. That is, Dr. Hiatt's also did not know critical information concerning claimant's noise exposure at work, use of hearing protection, or time spent in control booths (or otherwise protected from harmful noise exposure). As to Dr. Kauffman's opinion, he avers that he is not qualified to comment on causation and defers to Dr. Hiatt.

Consequently, on this record, claimant has not proven that exposure to noise at work was the major contributing cause of his left ear hearing loss or its worsening. ORS 656.802(1)(c).

ORDER

The Referee's order dated March 17, 1994 is affirmed.

November 21, 1994 Cite as 46 Van Natta 2389 (1994)

In the Matter of the Compensation of
BENJAMIN L. THORNTON, JR., Claimant
WCB Case No. 93-12755
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

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

The Referee found that all witnesses were credible and reliable except for one of the employer's service managers. (O & O at 3). 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 adverse credibility finding is based upon the observation of the witness' 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 other witnesses give sufficient cause to overturn the Referee's finding of credibility. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

SAIF argues that claimant's injury is not compensable under ORS 656.005(7)(b)(A) because claimant was an aggressor in the water fights on August 20, 1993, the day of his injury, and the water fights were not connected to the job assignment and amounted to a deviation of claimant's duties. ORS 656.005(7)(b)(A) provides that an "[i]njury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties" is not compensable.

The water fights and other forms of horseplay had been going on for a period of years. We find that the activities at issue in this case did not constitute "assaults or combats." Moreover, because supervisory and management personnel knew of and regularly participated in the water fight activities, we conclude that those activities did not amount to a deviation from customary duties. See Kessen v. Boise Cascade Corp., 71 Or App 545 (1984). Consequently, we conclude that ORS 656.005(7)(b)(A) does not apply in this case.

SAIF argues that even if ORS 656.005(7)(b)(A) does not apply, claimant's injury is not compensable because it did not arise out of his employment. According to SAIF, the employer did not acquiesce or condone water fights at the time of claimant's injury. We disagree.

Before an employer can acquiesce in or impliedly allow conduct, it must have actual or implied knowledge of that conduct. Maurice A. Frost, 45 Van Natta 1242 (1993). Acquiescence may be established by showing that the injurious activity was a "common practice or custom in the work place." Clark v. U.S. Plywood, 288 Or 255, 267 (1980). In Stark v. State Industrial Acc. Com., 103 Or 80 (1922), the court found that the horseplay that the worker had engaged in, which consisted of shooting an air-hose at a co-worker, was commonplace where he worked. The court stated that the accident "was an incident of such employment by reason of the appliance used in the work, and the custom which prevailed of the employees, without the infraction of any enforced rule of the establishment, diverting the use of the air hose to sport." Id. at 98 (quoted in SAIF v. Noffsinger, 80 Or App 640, rev den 302 Or 342 (1986)). (Emphasis added).

Similarly, in the present case, the employer was not actively engaged in a program to keep horseplay activity under control. Compare Brown v. Liberty Northwest Ins. Co., 105 Or App 92 (1990), rev den 311 Or 261 (1991) (the employer had a program to keep horseplay under control and had not acquiesced in it). Although the general manager may have wanted the water fights to stop, other supervisory personnel acquiesced in, participated in, and sanctioned the same conduct. In fact, claimant's immediate supervisor initiated the water fights on the day that claimant was injured. We conclude that management took no active, meaningful measures to end the water fights. We agree with the Referee's conclusion that claimant was injured 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 January 31, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, payable by the SAIF Corporation.

Board Member Haynes specially concurring.

I agree that the employer was not actively engaged in a program to keep horseplay activity under control. Brown v. Liberty Northwest Ins. Co., 105 Or App 92 (1990), rev den 311 Or 261 (1991). I feel compelled to reach that conclusion because management took no active, meaningful measures to end the water fights and because claimant's immediate supervisor initiated the breach of "no water fights policy" on the day of injury.

I write separately to make recommendations as to some procedures that would allow the employer to make a reasonable argument that it was "actively engaged in a program to keep horseplay activity under control." Brown v. Liberty Northwest Ins. Co., supra.

In this case, the record indicates the horseplay had been going on for a number of years and was common practice. Management had authorized a water fight that was supposed to end the horseplay. However, there is no indication in the record that the employer held a meeting with all employees to notify them of the prohibition of horseplay and warn them of potential sanctions. Furthermore, the employer did not actively enforce the "no horseplay policy."

Although a specific, written company policy regarding horseplay is not required, see Heath A. Nickel, 44 Van Natta 1171 (1992), it is recommended. I would further recommend that each employee be given a copy of the policy and be required to sign a document indicating his or her receipt and understanding of the policy. Most importantly, the employer must actually enforce the policy with sanctions. Those preventative measures would present the fact finder with a much closer question as to whether the employer was "actively engaged in a program to keep horseplay activity under control." Brown v. Liberty Northwest Ins. Co., supra.

November 22, 1994 Cite as 46 Van Natta 2391 (1994)

In the Matter of the Compensation of
EDWARD N. VIGIL, SR., Claimant
WCB Case No. 93-02943
ORDER DENYING RECONSIDERATION
Janelle Irving (Saif), Defense Attorney

Claimant, pro se, has submitted a "Motion to Compel Production of Additional Portions of the Agency Case Record." Inasmuch as claimant has requested judicial review of our October 7, 1994 order, we interpret his letter as a request for reconsideration. For the following reasons, we deny claimant's request.

Pursuant to our October 7, 1994 order, we adopted and affirmed a Referee's order which upheld the SAIF Corporation's partial denial of claimant's thoracic back condition. Claimant has petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). In addition, the 30-day period within which to withdraw and reconsider our order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1).

Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. See Carole A. Vanlanen, 45 Van Natta 178 (1993); Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Contending that we filed only "a partial record of the proceedings before the board related to claimant's claim," claimant requests that "the Board be required to produce as part of the record herein, the bare bones documents that established his right to file the aggravation claim at issue, (i.e. the final determination order and any orders related to claimant's original claim of disability)." In doing so, claimant acknowledges that the requested documents "are not the actual orders on appeal." Notwithstanding this concession, claimant requests that the documents be produced and made part of the record on judicial review because they are "necessary to the prosecution of this appeal."

In accordance with our statutory obligation, we have forwarded to the court the original copy of the hearing transcript, all exhibits, and copies of all decisions and orders entered during the hearing and on review. See ORS 656.298(5). Thus, we have fully complied with our duty and supplied the court with the entire record on which our decision was based. Since the information requested by claimant is not available in the record provided to the court and because the court's decision is based only on evidence which is contained in that record, claimant's request for further information essentially constitutes a motion to remand this case to the Referee to obtain and introduce additional evidence.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists

when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, the documents requested by claimant (such as "the final determination order and any orders related to claimant's original claim of disability") are either already in the record or we have taken official notice of their existence.[1] Specifically, copies of the January 27, 1988 Determination Order and October 11, 1988 stipulation (which awarded claimant a total of 30 percent unscheduled permanent disability) are in the record (Exhibits 9 & 11) and have previously been provided to claimant. Moreover, we adopted the Referee's finding which took official notice of the parties' March 21, 1991 stipulation (which increased claimant's award by 14 percent). In light of such circumstances, we are not persuaded that the record as presently developed lacks the documents or information to which claimant is referring.

In any event, the issue for resolution at hearing and on review was whether claimant's thoracic back condition was causally related to his 1984 compensable left knee injury. In light of such circumstances, we are unable to conclude that production of any "bare bones documents" described by claimant would be reasonably likely to affect the outcome of this case; i.e., establish that claimant's current thoracic back condition is causally related to his 1984 industrial injury or his compensable left knee condition.

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

IT IS SO ORDERED.

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[1] Since the SAIF Corporation submitted the exhibits for admission into the record, we assume that copies of those exhibits were also previously provided to claimant. In any event, because we have forwarded the exhibits to the court, we no longer have copies of those exhibits. Therefore, if claimant needs another copy of a particular exhibit (or the March 21, 1991 stipulation), it is recommended that he make arrangements with SAIF to secure that replacement copy.

November 23, 1994 Cite as 46 Van Natta 2392 (1994)

In the Matter of the Compensation of
ADAM J. DELFEL, Claimant
WCB Case No. 93-02416
ORDER ON REVIEW
Schneider, 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 Bethlahmy's order that set aside its "de facto" denial of claimant's right leg injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order. See Barnett v. SAIF, 122 Or App 279 (1993); see also Carling v. SAIF, 119 Or App 466 (1993); Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992) (citing Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) (A claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work.); Volk v. Birdseye Division, 16 Or App 349 (1974).

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 $1,200, to

be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, the value to claimant of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated April 19, 1994 is affirmed. For services on review, claimant's counsel is awarded a $1,200 attorney fee, payable by the insurer.

November 23, 1994 Cite as 46 Van Natta 2393 (1994)

In the Matter of the Compensation of
GEOFFREY E. FORCUM, Claimant
WCB Case No. 93-14326
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our October 26, 1994 Order on Review that reversed that portion of Referee Daughtry's order that upheld its denial of claimant's acute back sprain injury claim. SAIF asserts that our finding that claimant was a credible witness is not supported by the record.

We withdraw our October 26, 1994 order for reconsideration. After considering SAIF's arguments, we continue to find that claimant was a credible witness. Furthermore, we reject SAIF's assertion that the Referee found claimant not credible. The Referee found Mr. Shimp, one of the employer's witnesses, "to be an earnest, open straight-forward person, whose consistent testimony I have no reason to doubt." (Opinion and Order at 3). He found that claimant was "a very pleasant, friendly gentleman whose testimony was not entirely in harmony." (Id). Thereafter, the Referee characterized Shimp's testimony as "credible," but did not make a specific finding regarding claimant's credibility. (See id). Therefore, we made our own finding regarding that issue. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). For the reasons stated in our prior order, we continue to conclude that there is insufficient evidence on which to find that claimant was not credible.

Accordingly, our October 26, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 26, 1994 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
JUDITH K. NIX, Claimant
WCB Case No. 93-02704
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

The self-insured employer requests reconsideration of that portion of our October 31, 1994 order that awarded claimant's attorney an attorney fee equal to 25 percent of the increased compensation created by the order, not to exceed $3,800. Relying on Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), the employer argues that our order creates an unauthorized overpayment.

In order to further consider this matter, we withdraw our October 31, 1994 order. To further assist us in deciding this issue, we implement the following simultaneous supplemental briefing schedule. Both parties' supplemental briefs shall be due 14 days from the date of this order. In submitting their respective positions, the parties are requested to discuss the effect, if any, OAR 438-15-085(2), SAIF v. Rapaich, 130 Or App 216 (1994), Weyerhaeuser Co. v. Sheldon, 86 Or App 46 (1987), and Jane A. Volk, supra, 46 Van Natta at 684 n.3, may have on this matter. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAY A. NERO, Claimant
WCB Case No. 92-04986
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant requests reconsideration of our October 26, 1994 Second Order on Remand that declined to award his attorney a fee under ORS 656.388 or 656.382(1) for services performed in securing claimant's entitlement to a penalty under ORS 656.268(4)(g). Contending that his counsel must be compensated for his services in obtaining the penalty (which he asserts is encompassed within the definition of "compensation" under ORS 656.005(8), claimant argues that he is entitled to an attorney fee award under either ORS 656.388, 656.382(1), or 656.386(2).

In order to further consider claimant's motion, we withdraw our prior orders. The self-insured employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
STACIE PIERCE, Claimant
WCB Case No. 93-10727
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of those portions of Referee Galton's order that: (1) set aside its "de facto" denial of claimant's occupational disease claim for a right wrist condition; (2) awarded interim compensation; and (3) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are compensability, interim compensation and penalties.

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

Preliminarily, we note that Exhibit 21A (Dr. Isaacson's September 13, 1993 examination of claimant) was included with the record as "extraneous material." Although the record does not reveal whether Exhibit 21A was admitted, we note that the parties cite to this exhibit as part of the record. Moreover, the Referee also cites to Exhibit 21A within the Opinion and Order. Thus, we treat Exhibit 21A as being included in the record and have considered it in our deliberations. See generally, Glow I. Meissner, 45 Van Natta 43 (1993).

Additionally, the insurer disputes the Referee's calculation of the penalty assessed pursuant to ORS 656.262(10). Specifically, the insurer contends that claimant was only entitled to temporary disability benefits beginning September 8, 1993, not August 11, 1993 as the Referee found. The insurer argues that penalties can only be assessed against the compensation "then due" claimant between September 8, 1993 (the date the insurer asserts that the alleged "de facto" denial transpired) and September 10, 1993 (the date claimant filed her Request for Hearing). (App. Br. at 11). We disagree.

On August 17, 1993, the insurer accepted claimant's occupational disease claim for a left wrist condition. (Ex. 20). Pursuant to that acceptance, the insurer paid claimant total temporary disability (TTD) benefits from July 6, 1993 through August 10, 1993. However, the Referee found, and we agree, that, on June 11, 1993, claimant had filed an occupational disease claim for her right wrist condition as well. Inasmuch as that condition was disabling, we concur with the Referee's conclusion that claimant is entitled to further temporary disability benefits from August 11 (the date the insurer ended claimant's benefits under the left wrist claim).

Finally, because the insurer failed to timely accept or deny claimant's right wrist claim, the Referee assessed a penalty on the compensation "then due" claimant in the form of unpaid temporary disability benefits. ORS 656.262(10)(a). Contrary to the insurer's arguments, claimant's entitlement to temporary disability benefits for her right wrist condition does not end as of the date that she filed her Request for Hearing. See Roger G. Prusak, 40 Van Natta 2037, 2042 (1988). However, we modify the Referee's penalty assessment which awarded a penalty against the compensation "then due" through the date of the publication of the Opinion and Order.

Penalties can only be assessed upon the compensation "then due" as of the date of hearing. See Filogonia Reyes-Cruz, 46 Van Natta 1294, 1297 (1994). Consequently, we modify the Referee's order to assess a penalty against that compensation due claimant from August 11, 1993 through December 8, 1993 (the date of hearing), unless the compensation can be otherwise terminated pursuant to law prior to hearing. ORS 656.262(10)(a); Filogonia Reyes-Cruz, supra.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,500, 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 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. We further note that claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986). Finally, since her interim compensation award has been reduced, claimant is likewise not entitled to an attorney fee award under ORS 656.382(2) for services devoted to that issue.

ORDER

The Referee's order dated February 4, 1994 is affirmed in part and modified in part. In lieu of the Referee's interim compensation award and penalty assessment, claimant is awarded temporary disability from August 11, 1993 through the date of the December 8, 1993 hearing (unless termination of this compensation is otherwise authorized by law prior to the date of hearing) and a penalty equal to 25 percent of the aforementioned award (shared equally by claimant and her counsel). For services on Board review, claimant's counsel is entitled to an assessed fee of $1,500, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
STEVEN K. BAILEY, Claimant
Own Motion No. 91-0671M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys

The Farmers Insurance Group (Farmers) requests reconsideration of our July 29, 1993 Own Motion Order that authorized the reopening of claimant's January 18, 1982 low back injury claim. Farmers informs us that another insurer has ultimately been found responsible for claimant's current low back condition.

In extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding the filing deadlines under OAR 438-12-065(2). We find that, as discussed below, this case presents such extraordinary circumstances. Furthermore, the issue of subject matter jurisdiction may be raised at any time during the course of litigation. Schlect v. SAIF, 60 Or App 449 (1982). Therefore, we proceed with our reconsideration.

We had previously postponed action concerning claimant's request for reopening of his January 18, 1982 injury claim pending resolution of litigation regarding the responsibility for claimant's current low back condition. On September 25, 1992, Referee Michael Johnson issued an order in which he concluded that Liberty Northwest Corporation (Liberty) was responsible for claimant's current condition. (WCB Case Nos. 92-05890, 92-04226, 92-05367). Liberty requested review of that decision.

On July 29, 1993, the Board issued an Order on Review reversing that portion of Referee Johnson's order that found Liberty responsible for claimant's current low back condition. Instead, the Board found Farmers (the own motion carrier in this case) responsible for that condition. That same date, the Board, in its own motion capacity, issued an Own Motion Order authorizing the reopening of claimant's January 18, 1982 injury claim to provide temporary total disability compensation beginning the date claimant is hospitalized for surgery.

The Board subsequently reconsidered its July 29, 1993 Order on Review. In an Order on Reconsideration issued on November 4, 1993, the Board concluded that claimant had sustained a "new occupational disease" for which Liberty was responsible. That order has become final by operation of law.

The Board's own motion jurisdiction extends only to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Here, it has been finally determined that claimant has sustained a new occupational disease for which Liberty is responsible. Obviously, the aggravation rights have not yet expired on this new occupational disease claim. Therefore, the Board, in its own motion capacity, is without jurisdiction over this new claim. Accordingly, we withdraw our July 29, 1993 Own Motion Order.

Our prior authorization for own motion claim reopening may have created potential problems with the Reopened Claims Reserve in that it has been ultimately determined that we were without jurisdiction to authorize the reopening of the own motion claim. In order to resolve these problems, the Reserve may need to seek reimbursement from Liberty for any temporary disability benefits paid by

Farmers and reimbursed to Farmers by the Reserve. However, the Court of Appeals has held that the Board lacks authority to grant or deny reimbursement from the Reserve. SAIF v. Holmstrom, 113 Or App 242 (1992). This limitation necessarily includes any adjustment to the Reserve as outlined above. Thus, we are without authority to authorize any adjustment to the Reserve. Therefore, we advise Farmers and Liberty to notify the Director regarding the change in the status of this claim so that the Director may authorize any necessary adjustments. ORS 656.625.

We authorize Farmers to seek reimbursement from Liberty for any temporary disability benefits paid by Farmers on this "reopened" own motion claim but not reimbursed by the Reserve.

IT IS SO ORDERED.

November 29, 1994 Cite as 46 Van Natta 2397 (1994)

In the Matter of the Compensation of
LARRY J. BERGQUIST, Claimant
WCB Case No. 92-14459
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of that portion of Referee Daughtry's order that set aside its December 1991 denial of claimant's right wrist condition on the ground that the denial was premature. On review, the issue is the propriety of the employer's denial. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his right wrist at work on September 25, 1991. The next day, he filled out an in-house accident report regarding the injury. On October 1, 1991, claimant attended a previously scheduled physical examination with his attending physician, Dr. Morrison. Claimant mentioned the wrist incident, but did not seek or receive any treatment for the injury from Morrison at the time. Claimant did not lose any time from work as a result of this injury.

Subsequently, a representative from the employer's risk management office spoke to claimant, and concluded that claimant had sought medical treatment from Dr. Morrison for the wrist injury. The employer issued a written denial of the claim on December 23, 1991.

Claimant sought medical treatment for his right wrist in August 1992; surgery was recommended. Claimant had missed no work because of the wrist injury until then. Thereafter, claimant's attorney sent a letter to the employer, seeking reconsideration of the December 1991 denial. On November 2, 1992, the employer upheld the denial.

Claimant requested a hearing, challenging the December 1991 denial and the employer's November 1992 "de facto" denial. At hearing, the employer moved to dismiss the request for hearing as untimely filed. Claimant argued, inter alia, that the December 1991 denial was invalid because no claim had been filed. After taking no testimony, the Referee concluded that a claim had been filed and, on that and other grounds, allowed the motion to dismiss.

On review, we reinstated claimant's request for hearing and remanded the matter to the Referee. Larry Bergquist, 45 Van Natta 2140 (1993). We concluded that the parties should have been given the opportunity to present evidence to support their respective positions concerning whether claimant had filed a claim and whether the employer's denial was valid. Id. at 2141.

On remand, the Referee concluded that no claim had been filed when the employer issued its December 1991 denial, and accordingly, the Referee set aside the denial as a nullity. The Referee did not address the employer's November 1992 "de facto" denial, but concluded that, in view of the expert

and lay evidence, claimant had established compensability of his right wrist condition. The employer has requested Board review of that portion of the Referee's order that set aside the December 1991 denial.

Written notice of acceptance or denial of a claim must be furnished to the claimant within 90 days after the employer has notice or knowledge of the claim. ORS 656.262(6). A "claim" is defined as "a written request for compensation from a subject worker * * * or any compensable injury of which the subject employer has notice or knowledge." ORS 656.005(6) (emphasis added). We have said that "before a 'claim' can exist, a worker must have asserted a right to workers' compensation benefits or an existing and potentially work-related injury or disease must have come to the attention of the employer." Donna J. Halsey, 39 Van Natta 116, 118 (1987); see also Larry Bergquist, supra, 45 Van Natta at 2141. For workers' compensation purposes, a "compensable injury" is "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death." ORS 656.005(7)(a) (emphasis added). Accordingly, for a claim to exist on the basis of an employer's notice or knowledge of a potentially compensable injury or disease, the injury or disease must be one requiring medical services or resulting in disability or death. See Donna J. Halsey, supra, 39 Van Natta at 117, 118. If there is no claim, a denial is a nullity and has no effect. William F. Hamilton, 41 Van Natta 2195, 2198 (1989).

On review, the parties do not dispute that claimant did not make a written request for compensation before the employer issued its December 1991 denial. Rather, the dispute centers around whether the employer had notice or knowledge of a potentially work-related injury before it issued the denial. The employer argues that, because it had knowledge of claimant's potentially work-related injury before December 1991, a "claim" existed, even if claimant did not require medical services or experience any disability until after the denial issued. We disagree.

As stated earlier, ORS 656.005(6) defines "compensable injury" as a work-related injury that requires medical services or results in disability or death. At a minimum, then, for a "claim" to exist through the employer's notice or knowledge of a potentially work-related injury, the injury must have required medical services or resulted in disability or death.

Here, the record establishes that, before the employer issued its December 1991 denial, claimant neither required medical services, nor experienced any disability, as the result of his September 1991 right wrist injury. Indeed, claimant missed no work because of the injury before the December 1991 denial issued; moreover, although he mentioned the wrist injury to Dr. Morrison during his October 1, 1991 examination, claimant did not seek (or receive) medical treatment for that condition until August 1992, well after the employer issued its December 1991 denial.

Under the circumstances, we find that no "claim" was in existence at the time of the December 1991 denial. Accordingly, the denial was a nullity and has no effect. William F. Hamilton, supra. Therefore, the employer's denial, having no basis in law, did not require a response within the period of limitation of ORS 656.319(1)(a). Knapp v. Weyerhaeuser Co., 93 Or App 670, 674 (1988). Claimant's request for hearing is, therefore, not subject to dismissal on the ground that it was not filed within 60 days (or 180 days, with good cause, ORS 656.319(1)(b)) of the December 1991 denial. Id.

For these reasons, we affirm the Referee's decision setting aside the employer's December 1991 denial and finding claimant's right wrist condition compensable.

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 is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have 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 April 11, 1994, and amended May 10, 1994, is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,000 for services on review, payable by the self-insured employer.

In the Matter of the Compensation of
HOMER BETANCOURT, Claimant
WCB Case No. 93-06942
ORDER ON REVIEW (REMANDING)
Werst, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Mills' order that dismissed his June 9, 1993 request for hearing from a "de facto" denial of an aggravation claim. On review, the issue is dismissal. We vacate the Referee's order and remand.

The following procedural history appears from the parties' allegations and briefs on review.

Claimant has an accepted back injury claim that was closed in 1992. On June 9, 1993, claimant filed a request for hearing on an aggravation claim. On June 24, 1993, the self-insured employer issued a "back-up" denial of the original claim. On July 2, 1993, a Notice of Hearing for September 10, 1993 was issued. Prior to hearing, the employer requested and received a continuance to January 13, 1994. On December 28, 1993, the employer filed a motion to dismiss claimant's request for hearing on the aggravation issue because claimant had failed to request a hearing on the "back-up" denial within 180 days of that denial.

The Referee issued an order dismissing claimant's hearing request. The Referee reasoned that, because the employer's "back-up" denial of the original claim had become final, there could be no aggravation rights where the underlying claim was not compensable. The Referee did not convene a hearing, admit any evidence into the record, or take any testimony. Claimant requested Board review from the Referee's order of dismissal.

On review, claimant contends that his request for hearing should not have been dismissed. Claimant reasons that the employer waived its right to object to claimant's failure to file a separate request for hearing on the "back-up" denial. Specifically, claimant asserts that, in responding to claimant's request for hearing on the aggravation claim, the employer denied both claimant's aggravation claim and "all issues raised or raisable."

The employer contends that claimant must request a hearing for each denial claimant wants to raise before the Board. The employer further contends that, because claimant failed to timely file a separate request for hearing on the "back-up" denial, the denial has become final and any request for hearing on the derivative issue of aggravation must be dismissed for lack of jurisdiction pursuant to ORS 656.319.

Our review is limited to the record developed at the hearing level. In this case, because no hearing was convened and no evidence taken, we are unable to address the parties' specific contentions. Moreover, neither party had an opportunity to present evidence concerning the issue of whether claimant is presently entitled to a hearing on the merits of his hearing request. See Larry Bergquist, 45 Van Natta 2140 (1993); Ana R. Sanchez, 45 Van Natta 753 (1993).

We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Keinow's Food Stores v. Lyster, 79 Or App 416 (1986).

Under these circumstances, we conclude that the record is not sufficiently developed to address the parties' contentions. Therefore, a compelling basis for remand exists.[1]

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[1] We have faced a similar problem in recent cases. See e.g., Kathleen F. Gonzalez, 46 Van Natta 2288 (1994); Jack S. Koehler, 45 Van Natta 1728 (1993). We recognize the worthy goal of expeditiously resolving disputes. However, when a motion to dismiss is contested, as here, it is frequently more expeditious to develop a record before granting the motion to dismiss, thereby eliminating the need to remand if a party requests Board review.

Accordingly, we vacate the Referee's order and remand this matter to Referee Mills. The parties shall have the opportunity to clarify the issues for resolution, as well as present evidence regarding those issues. The Referee shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination and/or testimony. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated January 11, 1994 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to Referee Mills for further proceedings consistent with this order.

November 29, 1994 Cite as 46 Van Natta 2400 (1994)

In the Matter of the Compensation of
EDITH N. CARTER, Claimant
WCB Case No. 94-02825
ORDER ON REVIEW
Nancy FA Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Menashe's order that affirmed an Order on Reconsideration awarding 24 percent (76.8 degrees) unscheduled permanent disability for a cervical and shoulder condition. The insurer also objects to the Referee's admission of a "post-reconsideration" 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 except that we correct claimant's age at the time of injury to 48-years-old and the date that Dr. Gray measured range of motion to September 20, 1993.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the Referee admitted Exhibit 31, a "check-the-box" report from claimant's attorney to Dr. Gray, claimant's treating osteopath, asking Dr. Gray whether he agreed or disagreed with the medical arbiter's report. We agree with the insurer that, because the report was generated after the issuance of the medical arbiter's report, it is not admissible. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993). Furthermore, we find no merit to claimant's argument that she has a due process right to rely on the document. Thus, we do not consider Exhibit 31 on review.

Extent of Unscheduled Permanent Disability

Claimant has an accepted cervical and right shoulder strain. In September 1993, Dr. Gray declared claimant medically stationary and measured claimant's cervical and right shoulder range of motion. (Ex. 23).

In October 1993, examining orthopedic surgeon Dr. Farris evaluated claimant. Dr. Farris "suspected psychosocial factors influencing the symptom complex" and found "moderate to severe pain behavior." (Ex. 24-5, 24-6). Dr. Farris further indicated that his range of motion measurements were not valid, concluding that claimant had no "significant condition" in her right shoulder or cervical spine and, if she was impaired, such impairment was not related to her work activities. (Id). Dr. Gray concurred with the report. (Ex. 25).

In November 1993, however, Dr. Gray reported that his September 1993 measurements should be considered "appropriate for [claimant's] injury." (Ex. 26). Finally, in December 1993, Dr. Gray reported that claimant had "significantly improved with her range of motion and overall hand function" and, in view of continuing progress, he did not expect "any permanent impairment in this case." (Id).

In February 1994, Dr. Rand, medical arbiter, measured range of motion in claimant's cervical spine and right shoulder, finding that claimant was "status post cervical and right shoulder strain." (Ex. 29A-2, 29A-3).

The Referee relied on Dr. Rand's report in finding that claimant was entitled to 24 percent unscheduled permanent disability. The insurer asserts that claimant proved no entitlement to permanent impairment. The insurer relies on Dr. Farris' report and Dr. Gray's concurrence and Dr. Gray's subsequent report indicating that no permanent impairment was expected.

We are not persuaded by Dr. Farris' opinion that any impairment exhibited by claimant was invalid. We find that Dr. Gray, as the treating physician, was in a better position to evaluate the validity of claimant's range of motion since he had substantially greater contact with claimant in comparison to Dr. Farris' single examination. Dr. Gray provided affirmative evidence that he found claimant to be impaired based on the limited range of motion in her cervical spine and right shoulder. (Exs. 23, 26). Because Dr. Gray actually authored such reports, we find such evidence to be more persuasive than his "check-the-box" concurrence with Dr. Farris' report.

We also find unconvincing the insurer's contention that, because Dr. Rand did not specifically indicate that impairment was due to claimant's accepted conditions, his report does not prove entitlement to permanent impairment. Dr. Rand's impression of "post status cervical and right shoulder strain" was consistent with claimant's accepted conditions of cervical and right shoulder strain. Because Dr. Rand referred only to these conditions and indicated no other potential causes of claimant's impairment, we find that his report is most reasonably construed as showing that claimant's limited range of motion was due to the accepted conditions. See David J. Schafer, 46 Van Natta 2298 (1994).

Finally, we agree with the insurer that Dr. Gray's final report does provide evidence that claimant is not permanently impaired. The report, however, is only a prediction by Dr. Gray that claimant would not have permanent impairment in the future. Because Dr. Rand actually examined claimant several months after Dr. Gray generated his report and found limited range of motion, we are more persuaded by Dr. Rand's findings than Dr. Gray's prediction regarding permanent impairment.

Thus, we agree with the Referee that Dr. Rand provided the most reliable evidence of claimant's range of motion. Inasmuch as the parties do not contest the Referee's computation of claimant's permanent disability, including impairment, we adopt that portion of the Referee's order finding claimant entitled to 24 percent unscheduled permanent disability.

Claimant's attorney is entitled to an assessed fee for services on review regarding extent of permanent disability. See 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 $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 25, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer.

In the Matter of the Compensation of
GEORGE C. EGGERS, Claimant
WCB Case No. 94-01439
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of Referee Podnar's order which set aside its denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

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

The Referee found that by accepting claimant's cervical "pain," the employer accepted a symptom of claimant's cervical condition which was ultimately diagnosed as anteriolisthesis at C2-3.

On review, the employer contends that it accepted "thoraco cervical muscle soreness and pain" in a February 26, 1990 stipulation, and that because of the inclusion of the word "muscle," its acceptance was limited to only cervical pain which was muscular in nature. The employer further argues that since claimant's cervical pain was ultimately found not to be muscular in origin, the cause of claimant's current cervical symptoms was not within the scope of its acceptance. We disagree.

On August 14, 1989, the employer denied claimant's "cervical pain." By a stipulation dated February 26, 1990, the employer agreed that "[t]he August 14, 1989 denial of medical services related to cervical pain shall be rescinded." Based upon the language of the stipulation, we conclude that the employer specifically accepted "cervical pain." See Johnson v. Spectra Physics, 303 Or 49 (1987) (acceptance of a claim encompasses only those conditions specifically or officially accepted in writing).

Although at the time of the stipulation, Dr. Long believed the cervical pain was muscular in origin, claimant's cervical symptoms were ultimately attributed to anteriolisthesis of C2-3. Claimant's cervical symptoms at the time of his surgery were the same symptoms he experienced as a result of his injury in 1989. (Tr. 7; see also Ex. 9-2). By accepting claimant's "cervical pain" symptoms in the 1990 stipulation, the employer accepted anteriolisthesis of C2-3, the condition causing claimant's cervical pain. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988).

Accordingly, because the employer had previously accepted a claim for anteriolisthesis at C2-3, the employer is barred from now denying that 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated May 16, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

In the Matter of the Compensation of
FRANCISCO J. GUZMAN, Claimant
WCB Case No. 93-13881
ORDER ON REVIEW
Pamela Schultz, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Myzak's order that set aside a denial of claimant's low back aggravation claim.[1] On review, the issue is aggravation.

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

SAIF asserts that, under Richard L. Oviatt, 45 Van Natta 101 (1993), claimant has failed to establish the "diminished earning capacity" element of an aggravation claim. We disagree.

In Oviatt, before issuance of a Determination Order, the claimant's treating physician reported that the claimant had returned to work, was not handling it well and should be declared unable to work. Thereafter, the doctor noted that he doubted that it would be possible for the claimant to continue in the modified position. The claimant subsequently was unable to perform the modified job. Under those circumstances, we concluded that the record did not sustain the conclusion that, as a result of his worsened condition, the claimant's earning capacity had been diminished below the level fixed at the time of the last arrangement of compensation. Id. at 102.

Here, in May 1993, before claim closure, Dr. Collada, a one-time consulting physician, reported that claimant "was barely managing" to perform his modified duties. (Ex. 13-1). On August 24, 1993, however, Dr. Gooch, treating physician, reported that, although claimant continued to have chronic back pain syndrome, the plan was that he continue his modified work on a permanent basis. (Ex. 16).

The claim was closed on September 2, 1993. (Ex. 19). Thereafter, claimant experienced a symptomatic worsening of his back condition. (E.g., Ex. 21). On October 29, 1993, Dr. Gooch restricted claimant from all work. (Ex. 25A; see also Exs. 27A, 28A, 29A, 30AA, 30B). In a December 16, 1993 report, Dr. Gooch stated, "It is clear that working even at a limited level at his work exacerbates his symptoms and requires repeated time loss. This pattern of incapacitating symptoms was not expected when he was released for permanently modified work." (Ex. 32).

Here, as in Oviatt, there is pre-closure evidence suggesting that claimant was not handling his modified work very well. However, unlike Oviatt, no medical expert stated, before claim closure, that claimant should be declared unable to work; indeed, approximately a week before claim closure, Dr. Gooch, the treating physician, reported that claimant was to continue his modified employment permanently. On those grounds, we find Oviatt distinguishable. Rather, we conclude that the record as a whole (and particularly, a comparison of Dr. Gooch's August 24 and December 16 reports) supports the conclusion that, as a result of his worsening compensable low back condition, claimant's earning capacity was diminished below the level fixed at the last arrangement of compensation.

Accordingly, for the reasons asserted in the Referee's order, as supplemented herein, we conclude that claimant has established a compensable aggravation of his accepted low back condition. Therefore, we affirm the Referee's decision setting aside the denial of that condition.

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[1] This case has an unusual procedural posture. Claimant sustained a compensable low back strain in July 1989, while Liberty Northwest Insurance Corporation (Liberty) was on the risk. After he experienced increased back pain in August 1992, claimant filed an aggravation claim with Liberty and a new injury claim with SAIF, who was then on the risk. That claim was closed on September 2, 1993. Thereafter, claimant's symptoms worsened. Claimant filed the present aggravation claim, which Liberty denied. The Referee set aside that denial, and Liberty requested Board review. In the meantime, in an April 1994 Order on Review, we concluded that claimant had sustained a "new injury" in August 1992 and, therefore, that SAIF was responsible for claimant's 1992 claim. Thereafter, Liberty moved that SAIF be substituted as the carrier on all future matters involving the present claim. SAIF did not object to the motion, which we granted on July 7, 1994. See Diana L. Brett, 46 Van Natta 23 (1994).

Claimant is entitled to an 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 attorney for claimant's attorney's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 16, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

November 29, 1994 Cite as 46 Van Natta 2404 (1994)

In the Matter of the Compensation of
HUBERT W. JOHNSON, Claimant
WCB Case No. 94-00300
ORDER ON REVIEW
Fuchs & Fuchs, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Nichols' order that affirmed an Order on Reconsideration that awarded 19 percent (60.8 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 modification and supplementation.

On review, claimant contends that his unscheduled disability award should be increased to 25 percent. Specifically, he argues that the value for the adaptability factor should have been 3, instead of 1 (as the Referee found). We disagree.

In applying the standards for rating permanent disability, the Referee applied the temporary rules set forth in WCD Admin. Order 93-052. However, those rules expired on December 14, 1993, months before the hearing was held in this matter. In their place, the Director adopted the permanent rules set forth in WCD Admin. Order 93-056. See Michelle Cadigan, 46 Van Natta 307 (1994). The permanent rules apply only to those claims in which the claimant was medically stationary on or after July 1, 1990 and the claim was closed on or after December 14, 1993. OAR 436-35-003(1). All other claims in which the worker became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268 are subject to the standards in effect on the issuance date of the Notice of Closure or Determination Order. OAR 436-35-003(2).

Claimant's condition became medically stationary after July 1, 1990, and his claim was closed by Determination Order on June 21, 1993. Therefore, the applicable standards are set forth in WCD Admin. Order 6-1992.

Under the applicable standards, the value for the adaptability factor is zero if, at the time of determination, the worker had a physician's release to regular work. Former OAR 436-35-310(2). There is ample evidence in the record that claimant had a physician's release to regular work in 1992. On October 30, 1992, Dr. Throop reported his plan to "have [claimant] be conscious of his neck at work, but not change his job description." (Ex. 2.OA). Claimant testified that Dr. Throop released him to his regular job in 1992. (Tr. 12). Claimant added that the work release was made conditional on claimant's verbal assurance that he would take a "more conservative approach" to doing his job. (Tr. 12). However, he acknowledged that there were no written restrictions placed on his work release. (Tr. 27-28). Based on a preponderance of the evidence, we find that claimant had a physician's release to regular work. Under the applicable standards, therefore, the value for the adaptability factor should be zero. See former OAR 436-35-310(2).

If an adaptability value of zero was used, the computation of claimant's unscheduled disability award would be less than that awarded by the Order on Reconsideration. However, inasmuch as the insurer has not contested the Order on Reconsideration, we affirm its award of 19 percent unscheduled permanent disability.

Given our disposition of the merits of the extent of disability issue, we need not address the parties' arguments regarding the admissibility of claimant's argument and evidence concerning the proper DOT classification of his job at injury.

ORDER

The Referee's order dated April 11, 1994 is affirmed.

November 29, 1994 Cite as 46 Van Natta 2405 (1994)

In the Matter of the Compensation of
LORETTA J. KAUFMAN, Claimant
WCB Case No. 93-07644
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order which upheld the insurer's denial of claimant's occupational disease claims for a left shoulder bursitis/tendinitis condition and right carpal tunnel syndrome. In her brief, claimant contends that the Referee erred in declining to admit Exhibit 34, a letter from Dr. Bald, consulting physician. On review, the issues are evidence and compensability.

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

A hearing in this case was originally scheduled for August 1993. The Referee continued the August hearing, but froze the record except for depositions from Drs. Craft, Ordonez and Wilson. The parties deposed Drs. Ordonez and Craft. Dr. Wilson was not deposed. During Dr. Craft's November 19, 1993 deposition, the parties learned, for the first time, that Dr. Craft was in possession of chart notes from Dr. Bald, to whom Dr. Craft had referred claimant. An employer (who was a party to these proceedings at the time of the depositions) requested that Dr. Bald's chart notes be attached to Dr. Craft's deposition. The parties agreed that the chart notes and radiographic reports would be attached and submitted as deposition exhibits.

The hearing was reconvened on February 9, 1994. Dr. Wilson was present to testify for the insurer. Claimant sought to admit into evidence a January 10, 1994 letter from Dr. Bald. The Referee declined to admit the submitted exhibit on the grounds that the record previously had been frozen except for the three doctors' depositions.

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Pursuant to OAR 438-07-018(4), the Referee has the discretion to admit or exclude evidence not submitted in accordance with the Board's rules. See Steven S. Ewen, 45 Van Natta 207, 209 (1993). Moreover, 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. See Clifford L. Conradi, 46 Van Natta 854 (1994); Darrel L. Hunt, 44 Van Natta 2582, 2583 (1992).

Claimant argues that counsel for the insurer waived the agreement that the record would be frozen, and opened the door for Dr. Bald's Exhibit 34 by submitting chart notes from Dr. Bald during Dr. Craft's deposition. We review the Referee's evidentiary decision for abuse of discretion.

The Referee concluded that, had there not been a request to cross-examine certain doctors when the prior hearing convened, the parties would have gone forward with the August 1993 hearing without the evidence from Dr. Bald. (Tr. 14). Furthermore, the Referee noted that the parties had specifically requested that the previous Referee freeze the record. Therefore, the Referee declined to admit Exhibit 34. Additionally, in order to achieve fairness for each party, the Referee declined to allow the testimony of Dr. Wilson, the insurer's witness, at the hearing. (Tr. 19-20).

Here, we find that the Referee did not abuse his discretion by excluding Exhibit 34. Because the parties had requested that the record be frozen except for the doctors' depositions, we do not find that it was an abuse of discretion for the Referee not to reopen the record for an additional medical opinion. Consequently, we do not disturb the Referee's exclusion of the proffered exhibit.

ORDER

The Referee's order dated March 18, 1994 is affirmed.

November 29, 1994 Cite as 46 Van Natta 2406 (1994)

In the Matter of the Compensation of
PATRICIA M. KNUPP, Claimant
Own Motion No. 91-0716M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Gary D. Taylor, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 10, 1993 Notice of Closure that closed her claim with an award of temporary disability compensation from January 3, 1992 through November 25, 1993. SAIF declared claimant medically stationary as of September 23, 1993. Claimant contends that she is entitled to additional benefits because she is not medically stationary.

On April 7, 1994, the Board postponed action on claimant's request for review of SAIF's closure pending resolution of litigation that raised compensability issues regarding this claim. (WCB Case No. 93-15203). Subsequently, claimant withdrew her request for hearing. On September 27, 1994, Referee Nichols issued an order dismissing the matter. Thus, there remains no pending litigation regarding claimant's September 11, 1974 knee injury claim. Therefore, we proceed to review SAIF's closure.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the December 10, 1993 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence.

Claimant underwent compensable total right knee replacement surgery in June 1992. It is not clear from the record before us who performed that surgery. However, Dr. Poulson, orthopedist, treated claimant before and after the surgery. From October 25, 1993, through about December 22, 1993, claimant treated with Dr. Hill, orthopedist, while she was staying in California. After she returned to Oregon, claimant resumed treating with Dr. Poulson.

On December 2, 1993, Dr. Poulson viewed a video of claimant that was taken on September 23, 1993. In a December 6, 1993 letter to SAIF's claims adjuster, Dr. Poulson stated that "[t]he video identified [claimant] very well and showed that she walked without a limp and walked quite normally. It also showed that while going into the SAIF Building, she was using crutches but did more walking with them than she did using them." (See also December 2, 1993 chart note). Based on his viewing of this video, Dr. Poulson opined that claimant was medically stationary at the time the video was taken, i.e., on September 23, 1993.

On October 1, 1993, Dr. Zirschky, M.D., examined claimant at Dr. Poulson's request for a second opinion regarding claimant's total knee replacement. During that examination, Dr. Zirschky found that claimant had a marked antalgic component to her gait, used crutches, and avoided putting weight on the leg. (October 1, 1993 chart note). Dr. Zirschky found that claimant had no true medial lateral instability and that her anterior posterior instability could be controlled by her hamstrings with a little more gait training and strengthening. Regarding claimant's pain, he noted that there may be some component due to synovial impingement that could be improved by an arthroscopic evaluation and debridement, although he recommended against it. Finally, he noted that the "ultimate surgery to stabilize claimant's knee would be a fusion but before that was done, a replacement of the insert with a posterior stabilized component would be much more reasonable." Id.

Sometime in October 1993, claimant traveled to California to be with her husband, who had a job there. Claimant stayed in California approximately through December 1993 and treated with Dr. Hill during her stay. Dr. Hill first examined claimant on October 25, 1993.

On November 19, 1993, Dr. Hill opined "that there is no additional treatment that should be tendered while she is here. When she goes back to Oregon, consideration could be given to arthroscopies [sic] her knee. The yield on this has been problematical." (November 19, 1993 chart note). Dr. Hill last examined claimant on December 22, 1993. At that time, he reiterated that "the only other thing that I could think of to possibly further delineate her problems would be to arthroscope her knee. Again, it is questionable whether this will yield any change in her situation but, in view of her persistent problems, it is about the only other option." (December 28, 1993 letter from Dr. Hill to SAIF).

Claimant argues that Dr. Hill indicates that an arthroscopy would be beneficial to find out the nature of her persistent problems. On that basis, claimant argues that her condition was not medically stationary at claim closure. We disagree.

Dr. Hill essentially deferred to claimant's treating physician in Oregon when he stated that no treatment would be provided during claimant's stay in California but that an arthroscopy could be considered when claimant returned to Oregon. More importantly, Dr. Hill did not opine that such an arthroscopy would reasonably be expected to materially improve claimant's condition. ORS 656.005(17). Instead, he questioned whether an arthroscopy would result in any change in claimant's condition.

In addition, when claimant returned to Oregon, Dr. Poulson rejected the possibility of performing an arthroscopy because he did not think that it would help claimant and because it might make her condition worse. (February 3, 1994 chart note). In addition, he noted that he had discussed the possibility of an arthroscopy with Dr. Zirschky, who opined that he would not perform it because it very likely would not help claimant's pain. Dr. Poulson explained that, in performing an arthroscopy, Dr. Zirschky would be looking for ingrowth of synovium and how the joint surfaces were wearing. However, after telling Dr. Zirschky about the video, Dr. Poulson noted that Dr. Zirschky stated that, considering the video, he would not recommend performing an arthroscopy. Id. Thus, after learning about the video, Dr. Zirschky apparently recommended no further treatment for claimant.

Finally, claimant argues that Dr. Poulson's opinion is not persuasive evidence of her medically stationary status because he was not her attending physician at the time he authorized claim closure. We note that Dr. Hill filled out a change of attending physician form while claimant was treating with him in California. However, nothing restricts consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. See Francisco Villagrana, 45 Van Natta 1504 (1993) (treating physician who performed the claimant's surgery and followed his recovery was qualified to render an opinion regarding the claimant's medically stationary status regardless of whether he was the claimant's attending physician); Timothy H. Krushwitz, 45 Van Natta 158 (1993) (treating chiropractor was qualified to render an opinion regarding the medically stationary status of a worker he was treating even though he was, by statute, not qualified to serve as the worker's attending physician at the time he rendered the opinion).

Dr. Poulson followed claimant's treatment before and after her total knee replacement surgery. Therefore, Dr. Poulson is in a good position to judge claimant's medically stationary status. As claimant's long time treating physician, we find his opinion persuasive. In any event, Dr. Hill's opinion does not support a finding that claimant was not medically stationary at claim closure.

On this record, claimant has failed to meet her burden of proving that she was not medically stationary at the time her claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, SAIF's December 10, 1993 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

November 29, 1994 Cite as 46 Van Natta 2408 (1994)

In the Matter of the Compensation of
DENNIS R. LEWIS, Claimant
WCB Case No. 94-02018
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of those portions of Referee Livesley's order which: (1) set aside its partial denial of claimant's low back injury claim; (2) assessed a 25 percent penalty for its allegedly unreasonable failure to properly classify claimant's accepted shoulder and cervical claim as disabling; (3) directed SAIF to recalculate claimant's temporary disability; and (4) assessed a 25 percent penalty for an allegedly unreasonable failure to pay temporary disability. On review, the issues are compensability, claim processing, and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also offer the following summary of the relevant facts.

Claimant injured his right shoulder on November 2, 1993 and was placed on modified work by his employer at his regular wage. On November 9, 1993, claimant sought medical treatment for right shoulder complaints and was diagnosed with right shoulder tendonitis and muscle strain. Dr. Feldman released claimant for modified work. Claimant's employment was terminated on November 10, 1993 when he failed a drug test. He subsequently began reporting low back complaints. Claimant's injury claim was eventually accepted as a nondisabling right shoulder and cervical strain on January 17, 1994.

On February 16, 1994, the Department issued an Order Denying Assessment Of a Penalty Pursuant to ORS 656.262(10) after claimant alleged that SAIF unreasonably failed to pay temporary disability. On February 21, 1994, claimant requested a hearing regarding the Department's order before the Hearings Division. However, since the Department's order was not appealed pursuant to the review procedures of ORS 656.704(2), it became final.

On March 28, 1994, SAIF reclassified claimant's injury claim as disabling. On March 29, 1994, claimant filed a supplemental hearing request, raising the issues of penalties for failure to pay temporary disability and penalties and attorney fees for failure to properly classify the claim. Claimant's low back condition was denied on April 1, 1994, which claimant contested at the April 4, 1994 hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's low back condition was compensable. However, the Referee upheld the denial to the extent that it denied the compensability of claimant's spondylolisthesis at L-5 and his L5-S1 disc bulge.

The Referee further concluded that claimant's release to modified work on November 9, 1993 required that the claim be classified as disabling. Consequently, the Referee reasoned that claimant was entitled to a 25 percent penalty based on "all sums then due" for SAIF's unreasonable failure to properly classify the claim. The Referee also determined that claimant was entitled to a computation of temporary partial disability pursuant to temporary OAR 436-60-030, (WCD Admin. Ord. 94-050 effective February 28, 1994), as well as a 25 percent penalty under ORS 656.262(10) for failure to pay temporary disability.

Compensability

We adopt and affirm the Referee's reasoning and conclusion regarding the compensability of claimant's low back condition.

Claim Processing/Penalties

Claimant was provided modified work with full wages prior to his termination for reasons unrelated to his injury. SAIF concedes that the claim should have been classified as disabling from the beginning since claimant was partially disabled because of his work restrictions. See Sharman R. Crowell, 46 Van Natta 1728 (1994). However, SAIF contends that the Referee should not have assessed penalties because there is no proof that claimant's rate of temporary partial disability was anything other than zero. Therefore, it asserts it could not have unreasonably resisted the payment of compensation when claimant was not entitled to any temporary disability.

Moreover, SAIF argues that further litigation of the penalty issues is barred by res judicata since there was a final order issued by the Department's Compliance Section on February 16, 1994, which determined that claimant was not entitled to a penalty pursuant to ORS 656.262(10) for SAIF's failure to pay temporary disability. Inasmuch as claimant did not seek review of this order pursuant to ORS 656.704(2), SAIF asserts that the order is final and preclusive.

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 Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988).

We agree with SAIF that the Department's final order precluded claimant from contending that he is entitled to a penalty pursuant to ORS 656.262(10) for failure to pay temporary disability through February 16, 1994 (the date of the Department's order).[1] Moreover, we find that SAIF's claim processing was reasonable as of that date, given that under former OAR 436-60-030(2), claimant's temporary partial disability rate would be zero because of claimant's return to modified work at full wages.

However, as reasoned by the Referee, SAIF has a continuing duty to process a claim. See OAR 436-60-010(1) (insurer shall process claim in accordance with Chapter 656, WCD administrative orders and bulletins). Thus, effective February 28, 1994 (when the amended rule became effective), SAIF was required by temporary OAR 436-60-030 to compute temporary partial disability in reference to claimant's "earning power at any kind of work." See Stone v. Whittier Wood Products, 124 Or App 117 (1993). Such a directive involves evaluating all relevant circumstances that affect a worker's ability to earn wages. Under temporary OAR 436-60-030(2), post-injury wages are not dispositive of the rate of temporary partial disability.

Inasmuch as there is no evidence that SAIF recomputed claimant's temporary disability in accordance with the amended administrative rule, we agree with the Referee that SAIF's conduct was unreasonable. Consequently, claimant is entitled to recover a penalty for SAIF's unreasonable failure to pay temporary disability after the effective date of the temporary rule. Moreover, the Referee appropriately directed SAIF to make the proper calculation of claimant's temporary disability in light of the temporary rule and SAIF's general claim processing responsibilities.

Finally, SAIF has conceded that claimant's claim should have been originally classified as disabling. Because of this concession, we agree with the Referee that SAIF's conduct in misclassifying the claim was unreasonable. Therefore, a 25 percent penalty is appropriate. The amount will be

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[1] The Board is authorized to address a penalty issue if it is combined with other issues. However, the Director has exclusive authority under ORS 656.262(10) if the sole issue is entitlement to a penalty. See Albertson v. Astoria Seafood Corporation, 118 Or App 186 (1993). Here, claimant chose to present the penalty issue to the Director before requesting a hearing with the Board. Since he did so and the Director's order became final, the Board cannot address the issue of a penalty for SAIF's failure to pay temporary disability through February 16, 1994.

determined when SAIF calculates temporary partial disability in accordance with the "post-Stone" administrative rule and will be based on amounts "then due" from February 16, 1994 (the date of the Director's order declining to assess a penalty) until SAIF changed the claim classification from nondisabling to disabling on March 28, 1994. See Linda M. Akins, 44 Van Natta 108, 111 (1992) (penalty based on "amounts then due" when unreasonable conduct is corrected).

We have previously found that claimant is entitled to a penalty for SAIF's unreasonable failure to recalculate claimant's temporary disability. Generally, we would assess a penalty based on the temporary disability due from the date of the Department's February 16, 1994 order through the April 4, 1994 hearing. However, we are already assessing SAIF's "misclassification" penalty from February 16, 1994 to March 28, 1994. Inasmuch as we are precluded from assessing a 25 percent penalty on the same "amount then due" as a result of SAIF's misclassification conduct, see Kim C. Haragan, 42 Van Natta 311, 313 (1990), claimant's penalty for SAIF's unreasonable failure to pay temporary disability will instead be based on "amounts then due" for the period from March 29, 1994 to the date of the April 4, 1994 hearing.

Claimant's counsel is entitled to attorney fees for services on 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 assessed attorney fee for claimant's counsel's services on review regarding the compensability issue is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Finally, claimant's counsel is not entitled to an attorney fee for his services regarding the penalty issues. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated June 17, 1994 is affirmed in part and modified in part. In lieu of the Referee's penalty assessment, claimant is awarded: (1) a 25 percent penalty for SAIF's unreasonable misclassification based on the temporary disability due between February 16, 1994 and March 28, 1994; and (2) a 25 percent penalty for SAIF's unreasonable failure to recalculate claimant's temporary disability based on the temporary disability due between March 29, 1994 and April 4, 1994. Claimant's attorney shall receive one-half of these penalties under ORS 656.262(10). For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ZINAIDA I. MARTUSHEV, Claimant
WCB Case Nos. 93-11880, 93-11678 & 93-06337
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Claimant requested reconsideration of our July 29, 1994 Order on Review, which upheld the self-insured employer's denial of her current psychological/gastrointestinal condition. Claimant asserted that the employer's denial was an invalid pre-closure partial denial under United Airlines, Inc. v. Brown, 127 Or App 253 (1994).

On August 23, 1994, we abated our order to consider the motion for reconsideration and granted the employer an opportunity to respond. Having received the employer's response, we proceed with our reconsideration.

In Brown, 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. The court emphasized that, after a

claim is accepted, and in the absence of claim closure, termination of temporary disability is procedurally proper only when one of the circumstances in ORS 656.268(3) exists. United Airlines, Inc. v. Brown, supra, at 257.

In Sheridan v. Johnson Creek Market, 127 Or App 259 (1994), the court reversed a Board order which 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 stated that ORS 656.005(7)(a)(B) does not provide the procedural mechanism for the denial of an accepted claim.

In this case, the employer argues that claimant never raised the issue of entitlement to time loss either at hearing or in her brief to the Board. Therefore, according to the employer, the issue should not be considered for the first time on a motion for reconsideration.

We agree that claimant did not raise any issue regarding her entitlement to time loss relative to her psychological/abdominal claim. (Tr. 5). The only issue raised and litigated at the hearing was the causation of claimant's current condition. No procedural deficiency was raised concerning the denial. However, we have previously exercised our discretion and addressed the validity of a "pre-closure" denial for the first time on reconsideration even though no party had previously raised the issue. See Jean K. Elliott-Moman, 46 Van Natta 991 (1994).

In Elliott-Moman, the claimant sustained a compensable low back injury in 1989. Prior to claim closure, the employer issued a denial of the claimant's degenerative lumbar spine condition. We noted that, during the pendency of our review, the court in Brown and Sheridan had ruled that ORS 656.005(7)(a)(B) does not provide the procedural mechanism for the denial of an accepted claim prior to claim closure. Recognizing that no party had waived its right to challenge/defend the validity of the April 1992 denial itself, we considered the validity of the employer's "pre-closure" denial on reconsideration, even though the issue had not been previously raised by a party. In exercising our discretion to consider this "post-order" argument, we emphasized that the Brown and Sheridan holdings had issued during the pendency of our review. (On further reflection, since the Brown and Sheridan decisions issued in April 1994 and our initial order in Elliott-Moman was abated in March 1994, it is also apparent that the Brown and Sheridan holdings arose subsequent to the filing of the Elliott-Moman parties' appellate briefs.) Reasoning that the employer had issued its "resultant condition" denial of claimant's accepted claim prior to claim closure, and, therefore, it was an invalid "pre-closure" denial of an accepted condition under Brown and Sheridan, we set aside the denial.

Here, the briefing schedule was completed in March 1994. Not only were the parties' written arguments filed before publication of the Brown and Sheridan decisions, but prior to issuance of those court rulings, Board case precedent suggested that "pre-closure" denials under ORS 656.005(7)(a)(B) were permissible. See Daniel R. Bakke, 44 Van Natta 831 (1992). In light of such circumstances, we consider it appropriate to exercise our discretion and address on reconsideration claimant's contention that the employer's "pre-closure" denial was invalid.

Pursuant to an August 1992 stipulation, the employer accepted claimant's occupational disease claim for "adjustment disorder with physical complaints and anxious mood." On May 24, 1993, prior to claim closure, the employer issued a denial of claimant's current psychological/abdominal claim. The employer contended that claimant's employment was no longer the major contributing cause of her condition. The employer did not close the claim until June 4, 1993, when it issued its Notice of Closure. Inasmuch as the employer issued its "resultant condition" denial of claimant's accepted condition before it had closed the claim, the employer's May 24, 1993 denial is an invalid "pre-closure" denial of an accepted condition. Accordingly, we set it aside. United Airlines v. Brown, supra; Sheridan v. Johnson Creek Market, supra; Jean K. Elliott-Moman, supra.

Given our conclusion, claimant's counsel is entitled to an attorney fee for services at hearing and on review, including reconsideration, regarding the denial of claimant's current psychological/abdominal condition.[1] ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying

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[1] We note that claimant is represented by a different attorney on reconsideration. However, the specific manner in which our attorney fee award is to be shared by claimant's current and former counsel is a matter to be decided between them, not this forum. Gabriel Zapata, 46 Van Natta 403, 405 n.1 (1994). In other words, we award one attorney fee payable by the employer to claimant's current attorney of record (the attorney who has represented claimant on reconsideration). The particular manner in which that fee will be subsequently distributed among claimant's current and former attorney is a matter between them.

them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services is $3,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's 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, and in lieu of our July 29, 1994 Order on Review, we hold as follows. The Referee's order dated January 6, 1994 is reversed in part and affirmed in part. That portion which upheld the employer's denial of claimant's current psychological/gastrointestinal condition is reversed. The claim is remanded to the employer for processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing, on review and on reconsideration, claimant's counsel is awarded an assessed attorney fee of $3,500, to be paid by the employer. 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
DARRYL D. MAXSON, Claimant
WCB Case No. 93-07637
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Howell's order that upheld the insurer's denial of claimant's injury claim for a gastrointestinal infection. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On March 5, 1993, claimant, who worked as a pump truck operator, filled the water tank with creek water. During that afternoon, he drank from the tank. That evening, he became nauseous and over the next two days he developed vomiting, diarrhea and a fever. On March 8, 1993, claimant sought emergency room treatment for his gastrointestinal symptoms. Blood and stool samples were taken. Claimant developed signs of appendicitis that led to an exploratory laparoscopy and appendectomy. On March 17, 1993, claimant was diagnosed with an acute campylobacter jejuni gastrointestinal infection.

The Referee concluded that claimant failed to establish the compensability of his injury claim for the gastrointestinal infection on the basis that claimant had merely disproven other possible explanations of how the injury or disease occurred. See ORS 656.266. We agree that claimant's gastrointestinal infection is not compensable, but for different reasons.

Two physicians offered opinions on causation, Dr. Bailey, claimant's attending physician, and Dr. Bracis, internist, who performed a records review.

Due to the number of potential causes of claimant's infection, the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, Dr. Bailey affirmatively concluded that, although the source of the campylobacter organism is frequently obscure, the probable cause of claimant's gastrointestinal illness was the water that claimant drank from the tank he filled from a creek. (Exs. 13 and 19; Tr. 6 through 10). We find that Dr. Bailey did more than merely disprove other possible causes. Nevertheless, as discussed below, the evidence as a whole remains in equipoise.

Dr. Bracis offered a contrary opinion. He pointed out that there are a number of possible sources of campylobacter infection and opined that an exposure to contaminated water would be neither more nor less likely than any of the other possible sources. Moreover, he also opined that the onset of claimant's symptoms after an incubation period of mere hours made the drinking water contact less likely as a source of the infection. He concluded that, although claimant's clinical illness was best explained as campylobacter enteritis, the source remained unclear, absent data that would implicate the tank from which claimant drank the water. (Ex. 17).

We find that such circumstances present a persuasive reason not to defer to Dr. Bailey's opinion. Instead, we conclude that the opinions are in equipoise. Therefore, claimant has failed to carry his burden to prove by a preponderance of the evidence that his injury claim is compensable.

ORDER

The Referee's order dated January 27, 1994 is affirmed.

In the Matter of the Compensation of
JEFF McQUOWN, Claimant
WCB Case No. 93-08697
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Referee Lipton's order that: (1) set aside its partial denial of claimant's right knee injury claim; and (2) assessed a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

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

On an April 16, 1993 intake form at the office of Dr. Pitts, claimant's family physician, claimant reported right knee pain. (Ex. 26-2).

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions regarding compensability, with the following supplementation.[1]

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[1] The employer's August 3, 1993 partial denial denied a right knee condition and a preexisting L2-3 degenerative disc condition. (Ex. 23). The Referee's order did not address the latter condition. On review, the employer asks us to uphold the denial of that condition. Because the parties did not litigate that issue at hearing (claimant does not address it on review, either) and because the Referee's order specifically sets aside only the employer's denial of claimant's right knee condition, we find that no further action is necessary.

The employer argues that the Referee erroneously relied on the opinions of Dr. Neitling, treating orthopedic surgeon, who in turn relied on claimant's incorrect history of no right knee problems before April 1993 in concluding that claimant's current right knee condition was compensable. We disagree.

The record reflects that, after Dr. Neitling was apprised that claimant had reported some right knee instability to Dr. Pitts in 1991, he nonetheless adhered to his opinion that claimant's 1993 right knee condition was compensably related to his April 1993 work accident. In particular, based on his examination of claimant, Dr. Neitling concluded that claimant's current right knee problems were the result of an acute injury, as opposed to the residual effects of an earlier injury. (Ex. 30a-13 to -15).[2] We find that explanation persuasive enough to overcome the employer's argument.

The employer also argues that claimant has failed to establish the compensability of his right knee condition, because he did not complain of right knee problems contemporaneously with his low back problems following his April 13, 1993 work accident. Particularly, the employer argues that Dr. Neitling's explanation that claimant's excruciating back pain could have masked his less serious right knee pain is an unhelpful generalization. We disagree.

The record establishes that, on April 13, 1993, claimant slipped at work and immediately experienced severe low back pain. At the time, he also noticed that his right knee "popped," but he did not immediately experience any significant right knee pain. Three days later, on April 16, claimant noted right knee pain on Dr. Pitts' office intake form. (Ex. 26-2). On April 19, claimant reported right knee pain to a physical therapist. (Ex. 6). Dr. Pitts first recorded claimant's right knee complaints in an April 26, 1993 chart note. (Ex. 10).

Claimant thereafter consulted Dr. Neitling, orthopedic surgeon, who began treating his right knee condition. Neitling concluded that claimant's right knee condition was work-related. (Ex. 29). In deposition, Dr. Neitling stated that, under the circumstances, it was not inappropriate for claimant to wait until April 16 to report any right knee symptoms. (Ex. 30a-15).

In contrast, Dr. Wayson, an emergency department staff physician who treated claimant on April 16, 1993, opined that, if claimant had had a knee injury that day, it would have manifested itself somehow during claimant's nearly three-hour emergency department stay. (Ex. 30). Particularly, Dr. Wayson noted that there was no evidence of bone pain during a patellar reflex examination. (Id.)

Of the two, we find Dr. Neitling's analysis more persuasive. In view of the severity of claimant's back pain, as compared with his less significant right knee symptoms, we find convincing Dr. Neitling's conclusion that the former condition likely masked any symptoms of the latter until several days after the accident. We are not persuaded by Dr. Wayson's conclusions to the contrary, because she did not conduct an in-depth examination of claimant's right knee and because the medical records reflect that claimant was twice medicated with injections of pain medication during his stay in the emergency department. That Dr. Wayson did not address the impact, if any, of the injections on the lack of claimant's right knee complaints on April 13 undercuts the persuasiveness of her opinion. Furthermore, Dr. Wayson's examination of claimant took place while claimant was "lying quietly." (Ex. 3B-1).

In sum, for the reasons set forth in the Referee's order, as supplemented herein, we agree that claimant has established the compensability of this right knee condition. Accordingly, we affirm the Referee's decision setting aside the employer's partial denial of that condition.

Penalties

We adopt the Referee's conclusions regarding penalties, with the following supplementation.

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[2] Dr. Neitling also stated that it was not uncommon for people to fail to report minor incidents. (Ex. 30a-14). Claimant testified that, in 1991, during an examination for an unrelated condition, he reported to Dr. Pitts that he had "bumped" hit his right knee on a steering wheel. (Tr. 11). Dr. Pitts referred claimant to another physician; claimant did not follow up with the referral, because he did not think it was warranted. (Id.)

The employer argues that, because it had a legitimate doubt about the compensability of claimant's right knee condition, its denial was not unreasonable and, hence, there was no basis for assessing a penalty. We disagree.

In determining if a denial is unreasonable, the question is whether, at the time of the denial, the carrier had a legitimate doubt regarding its liability for the claim. If the carrier had a legitimate doubt about its liability, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The reasonableness of the carrier's conduct must be evaluated in light of information available to it at the time of denial. Id.

The employer's claims processor maintained that he did not have sufficient evidence on August 3, 1993 to accept claimant's right knee condition. Specifically, as bases for denying the right knee condition, the claims processor relied on the facts that: (1) claimant did not complain of right knee pain on April 13, 1993, either at work or during his emergency department stay; (2) an MRI showed a potentially old right knee injury; and (3) claimant's right knee condition was not mentioned in Dr. Pitts' chart notes until April 26. (Tr. 54, 61, 68, 75).[3] On July 13, 1993, the claims processor directed Dr. Farris, examining physician, not to address claimant's right knee condition. (Ex. 19aa).

Under the circumstances, we conclude that the employer did not have a legitimate doubt about its liability for claimant's right knee condition. In determining that claimant's right knee condition should be denied, the claims processor relied on his own "medical expertise." He concluded, without the benefit of any expert medical opinion, that claimant's failure to report any right knee condition on the date of injury was an indication that the claim was not compensable; he also purported to evaluate an MRI report, concluding that it was evidence that claimant's right knee condition was not related to his April 13 work accident. Under the circumstances, we conclude that, although the claims processor may have harbored personal doubts regarding the compensability of claimant's right knee condition, those doubts were not legally legitimate. See Brown v. Argonaut Co., supra. This conclusion is strengthened significantly by evidence that the claim processor directed the examining physician not to address claimant's right knee condition.

For these additional reasons, we conclude that, at the time of denial, the employer did not have a legitimate doubt regarding its liability for claimant's right knee condition. It follows that its denial was unreasonable. Therefore, we affirm the Referee's assessment of a penalty for the employer's unreasonable denial.

Claimant's counsel 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 assessed attorney fee for claimant's counsel's services on review regarding the compensability issue is $1,000, to be paid by the employer. 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 and the value of the interest involved. Claimant's counsel is not entitled to a fee for services related to the penalty issue. Saxton v. SAIF, 80 Or App 233, rev den 302 Or 159 (1986).

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[3] The employer did not obtain the April 16, 1993 intake questionnaire indicating claimant's right knee complaints until after the denial issued. (Tr. 57).

The claims processor relied on an alleged and unrecorded conversation with Dr. Neitling in which Neitling purportedly said that it was possible that claimant's right knee condition had occurred before April 13, 1993. (Tr. 65, 68). We agree with the Referee's conclusion to disregard this unrecorded conversation on the ground that it is suspicious that such a significant conversation would not have been somehow recorded.

The claims processor's decision to deny claimant's right knee condition was also predicated on claimant's failure to mention his right knee during a conversation with the claims processor. We find that basis insufficient to support a legitimate doubt regarding the employer's liability. First, there is no evidence regarding when this conversation occurred or what the conversation was about. Second, and in any event, the claims examiner was engaging in his own "medical" analysis in determining that claimant's failure to mention a right knee condition was somehow relevant to the inquiry.

ORDER

The Referee's order dated April 20, 1994 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000 for services on review regarding the compensability issue, to be paid by the self-insured employer.

November 29, 1994 Cite as 46 Van Natta 2416 (1994)

In the Matter of the Compensation of
MELVIN L. NELSON, Claimant
WCB Case No. 93-11746
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Lipton's order that: (1) set aside its partial denial of claimant's left tarsal tunnel condition; and (2) authorized surgery for that condition as a reasonable and necessary medical service. Claimant cross-requests review asserting that the Board should remand the matter to the Referee to consider Claimant's Exhibit 215 (a December 21, 1993 medical opinion from Dr. Grimm). On review, the issues are compensability, medical services, and evidence.

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

Claimant suffered a compensable left ankle injury on December 12, 1991. The employer accepted the condition as a left ankle sprain. Thereafter, claimant experienced progressively worsening left foot problems and was treated by several physicians. On April 21, 1993, claimant's most recent treating doctor, Dr. Puziss (orthopedic surgeon), diagnosed claimant's left foot condition as tarsal tunnel syndrome. Dr. Puziss also found, based upon nerve velocity conduction studies, that claimant had asymptomatic tarsal tunnel syndrome in the right leg as well. The parties do not dispute Dr. Puziss's diagnoses; rather, they disagree over whether the left tarsal tunnel condition is a compensable consequence of the December 1991 injury, or simply idiopathic in nature. See ORS 656.005(7)(a)(A).

Considering the passage of time since claimant's compensable left ankle strain, his persistent left ankle problems since that injury and the divergence among the medical opinions, we find that this case involves expert analysis, rather than expert external observation. Therefore, we do not give special credit to the evidence from treating physicians as opposed to other doctors. Allie v. SAIF, 79 Or App 284, 287 (1986); Hammons v. Perini, 43 Or App 299 (1979). Where the medical opinions are divided, we generally rely on physicians who are specialists in the field of question. Abbott v. SAIF, 45 Or App 657, 661 (1980).

Dr. Puziss opined that the major contributing cause of claimant's left tarsal tunnel condition was his compensable injury on December 12, 1991. (Ex. 210). At hearing, Dr. Puziss testified that he has treated 20 to 30 patients for the relatively uncommon problem of tarsal tunnel syndrome. (Tr. 39). Of those, he has performed approximately 10 or 12 surgical decompression procedures of the type proposed to treat claimant's condition. (Tr. 15). In claimant's case, Dr. Puziss opined:

> "I felt that the major cause of the tarsal tunnel syndrome was swelling of or around the tibial nerve, caused by the trauma to his ankle which caused some swelling of the structures in the tarsal tunnel, and that in all probability, the patient has developed some varicose veins inside the tarsal tunnel as a result of this compression. . . . [M]y reasoning is that the patient had a subtle but asymptomatic slowing of the tibial nerves bilaterally, but that the chronic swelling from his original ankle sprain injury left him with impairment or compression of the tibial nerve in the tarsal tunnel . . ." (Tr. 15-16).

Dr. Grimm (neurologist) conducted a neurological review of claimant on December 21, 1993. (Ex. 212). Dr. Grimm concurred with Dr. Puziss' opinion and stated that: "[i]n my opinion, [claimant's] left tarsal tunnel syndrome is a chronic consequence of his December, 1991 OJI [on-the-job injury]." (Ex. 212-2). Dr. Grimm further stated that a surgical release of claimant's left tarsal tunnel was "the best chance for a functional recovery." (Ex. 212-2).

On March 16, 1993, Dr. Farris (orthopedic surgeon) examined claimant at the request of the employer. (Ex. 179). Dr. Farris opined that claimant's December 1991 injury was the major contributing cause of his left ankle condition, which he diagnosed as "post contusion left heel with residual plantar fascitis and possible Haglund's disease." (Ex. 179-8). In a May 7, 1993 letter to the employer's counsel, Dr. Farris stated that he had reviewed Dr. Puziss' diagnosis of tarsal tunnel syndrome, but that claimant did not have that syndrome when he examined him previously on March 16. (Ex. 191-1).

On July 1, 1993, Dr. Farris conducted a second examination at the employer's request, in conjunction with Dr. Peterson, M.D. (Ex. 198). Drs. Farris and Peterson concurred with Dr. Puziss' diagnosis of left tarsal tunnel syndrome, but opined that the "15-month delay in the development of symptoms casts serious doubt on the proposition that the tarsal tunnel syndrome is related to the industrial injury." (Ex. 198-6). They also stated that, although a tarsal tunnel surgical release has a normal success rate of 75 percent, they did not believe that claimant would "benefit substantially" from this procedure. (Ex. 198-7). Dr. Wong (specializing in electrodiagnostic medicine) authored an August 27, 1993 letter to the employer's counsel wherein he agreed with the conclusions reached by Dr. Farris and disagreed with the recommendations of Dr. Puziss. (Ex. 205).

In an August 27, 1993 letter to the employer's counsel, Dr. Gripekoven (orthopedic surgeon) opined that claimant's December 1991 left ankle sprain was not the major contributing cause of his tarsal tunnel condition: "It would be extremely unusual for this condition to have developed many months after his injury. . . . I feel that the prognosis for surgical release of the tarsal tunnel is very guarded." (Ex. 204). Rather, Dr. Gripekoven believed that the etiology of claimant's tarsal tunnel was unexplained. (Ex. 204).

The employer argues that Dr. Puziss is not persuasive because he has an inaccurate history. Specifically, the employer contends that Dr. Puziss wrongly assumed that claimant experienced chronic left ankle swelling as a result of the December 1991 injury. (App. Br. at 6). The employer would instead have us rely upon the opinions of Dr. Farris and Dr. Gripekoven, who essentially believe that claimant's left tarsal tunnel condition is idiopathic in origin.

We do not find Dr. Puziss' history to be inaccurate. Dr. Puziss explained that claimant's December 12, 1991 sprain could have been relatively mild without noticeable, or long-lasting, external swelling. (Tr. 69). Moreover, in discussing swelling and claimant's left ankle, Dr. Puziss was addressing internal swelling within claimant's tarsal tunnel, not the external swelling of the ankle itself. (Tr. 17, 49-50). Therefore, we do not find that Dr. Puziss made any assumptions which would cause us to discount his medical opinion. Cf. Mal v. Unique Building Maintenance Co., 93 Or App 703, 707 (1988) (Physician's opinion held to be less persuasive because he was not aware of the claimant's non-work related activities). Therefore, we proceed to weigh the persuasiveness of the relevant medical opinions.

Dr. Farris testified that he had not performed a surgical decompression of the tarsal tunnel since 1986 or 1987. (Tr. 90). He explained that he has "cooled off on tarsal tunnel releases" because he has been "unhappy with my results, and based on the people that came to me that saw my colleagues that weren't getting much better, I started to really question the value of the release." (Tr. 90). Nonetheless, Dr. Farris agreed with Dr. Puziss that a surgical release would provide a 75 percent chance of alleviating claimant's tarsal tunnel syndrome. (Tr. 28, 63).

Dr. Puziss stated that it was "natural" for tarsal tunnel to develop over a long period of time after a traumatic injury. (Tr. 67). Dr. Farris primarily based his opinion on his belief that claimant's tarsal tunnel condition would have presented itself "within two or three months of the injury if you were going to relate it specifically to a trauma." (Tr. 93). Yet, Dr. Gripekoven noted that claimant was experiencing left ankle pain eight days following the injury. (Ex. 102-2). Moreover, the evidence indicates that claimant's left ankle symptoms progressively worsened thereafter. (Exs. 103, 130-1, 135, 137, 138, 140-1, 169-3, 173, 176, 179).

We find that the medical evidence gives greater support to Dr. Puziss' opinion of a slow and gradual onset of tarsal tunnel syndrome that did not become objectively verifiable until many months

later. In contrast, Drs. Farris and Gripekoven opined that, since such a long period of time passed before claimant's tarsal tunnel was diagnosed, unspecified idiopathic factors must be at work.

Considering Dr. Puziss's considerable experience with tarsal tunnel syndrome, his successful experience performing surgical decompressions to relieve that syndrome, and the thoroughness of his opinion, we find Dr. Puziss's opinion more persuasive than either Drs. Farris, Gripekoven or Wong. Abbott v. SAIF, supra.

As noted, claimant has bilateral nerve slowing in both lower extremities, but only his left ankle is symptomatic. Dr. Puziss explains that it is "natural" for tarsal tunnel to develop several months after a traumatic injury. (Tr. 67). However, neither Dr. Farris nor Dr. Gripekoven address why purely idiopathic processes are only affecting claimant's left ankle when that predisposition exists bilaterally. Under these circumstances, we find Dr. Puziss' opinion to be more complete and well-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986). Thus, for all the above-mentioned reasons, we rely on the expert medical opinion of Dr. Puziss, and the concurrence of Dr. Grimm, that claimant's left tarsal tunnel condition is a compensable consequence of his December 12, 1991 injury. ORS 656.005(7)(a)(A).

Lastly, the Referee concluded that a surgical tarsal tunnel release is a reasonable and necessary medical service to treat claimant's left ankle condition. We agree.

To establish entitlement to compensation for medical services under ORS 656.245(1), a claimant must prove the reasonableness and necessity of the medical services. James v. Kemper Ins. Co., 81 Or App 80, 84 (1986). Based on Dr. Puziss' opinion, we find that the proposed surgery is likely to be of significant curative benefit. See Tina M. Lingar, 41 Van Natta 420, 424 (1989). Accordingly, we adopt the Referee's finding that the proposed medical service is reasonable and necessary for treatment of claimant's compensable left tarsal tunnel condition. ORS 656.245(1); James v. Kemper Ins. Co., supra.

Given our conclusion that claimant's condition is compensable and the proposed surgery is reasonable and necessary, we need not address the evidentiary issue.

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

ORDER

The Referee's order dated January 21, 1994 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $2,000, payable by the self-insured employer.

November 29, 1994 Cite as 46 Van Natta 2418 (1994)

In the Matter of the Compensation of
RICHARD A. SCHIEL, Claimant
WCB Case Nos. 93-13653 & 93-03851
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee McCullough's order that declined to grant permanent total disability.[1] On review, the issue is permanent total disability.

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[1] We note that, although claimant does not expressly seek a permanent partial disability award on review, he argues that he has experienced additional permanent impairment as a result of the 1992 injury, based on a comparison between his impairment at the time his previous workers' compensation claim was closed and his current impairment. Claimant's argument is not persuasive, because the medical evidence indicates that claimant's current impairment is solely due to residuals of the surgeries that resulted from the prior injury. (Exs. 20 and 28-4).

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated April 4, 1994 is affirmed.

In the Matter of the Compensation of
VICTORIA L. SPRINGER, Claimant
WCB Case No. 93-11871
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Peterson's order that: (1) declined to dismiss claimant's request for hearing as untimely filed; and (2) set aside the insurer's denial of claimant's bilateral carpal tunnel syndrome (CTS) claim. On review, the issues are the timeliness of claimant's request for hearing and, alternatively, compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

At hearing, the insurer moved to dismiss claimant's hearing request on the ground that it stated a denial date of August 19, 1993, rather than the correct date of August 23, 1993. Claimant moved to amend the request for hearing to include the correct denial date. After determining that there was no evidence of any other outstanding denials pending between claimant and the insurer, the Referee granted claimant's motion and denied the insurer's motion. The insurer argues that the Referee's ruling was in error, because the hearing request is legally insufficient in that it lacked the correct denial date.[1] We disagree.

It is well understood that a claimant has an obligation to request a hearing in response to each denied claim. Naught v. Gamble, Inc., 87 Or App 145 (1987). In other words, a request for hearing must be referable to a particular denial. Guerra v. SAIF, 111 Or App 579, 584 (1992). To determine whether a a hearing request is referable to a particular denial, we consider the request itself, read as a whole and in the context in which it was submitted. See Kevin C. O'Brien, 44 Van Natta 2587, 2588 (1992).

On this record, we conclude that claimant's hearing request constituted an adequate request for hearing from the insurer's August 23, 1993 denial. Although the request stated an August 19 denial date, the record reflects that the insurer's August 23 denial was the only outstanding denial at the time. Under the circumstances, we conclude that the hearing request was referable to the August 23, 1993

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[1] On review, the insurer also argues that claimant's hearing request is legally insufficient because it lacks a claim number, a WCD number and a date of injury. Because the insurer did not raise those issues as bases for a dismissal at hearing, we are not inclined to address them on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, we would consider such requirements to be "permissive," rather than jurisdictional. See Kimberly L. Murphy, 41 Van Natta 847 (1989) (Board not authorized to limit its jurisdiction to less than that provided by statute; therefore, a request for Board review need only state that a party requests review). Consequently, the failure to include such information in a hearing request (although certainly helpful to the expeditious processing of the request) would not be grounds for dismissal.

denial. See id. (the claimant's affidavit, which identified the carrier that had denied compensability, coupled with a request for expedited hearing, was clearly referable to the carrier's denial because only that denial denied compensability).

For these reasons, then, we conclude that the Referee did not err by allowing claimant to amend the hearing request to reflect an August 23, 1993 denial date, and by denying the insurer's motion to dismiss the hearing request.

Compensability

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

Dr. Eilers, treating orthopedic surgeon, and Dr. Arrington, treating physician, concluded that claimant's CTS was related, in major part, to her duties as an operating room nurse for the insurer's insured. We agree with the Referee that there are no persuasive reasons not to defer to their opinions. See Weiland v. SAIF, 64 Or App 810 (1983).

In contrast, we find persuasive reasons to give minimal probative weight to the opinions of Dr. Button, hand surgeon, who examined claimant on the insurer's behalf. The gist of Dr. Button's opinion is that, because he has seen only two cases of CTS in operating room personnel during his career, it was unlikely that claimant's CTS was work-related. (See Ex. 36-18). Button also concluded that, in view of claimant's status as a registered nurse and her recent history of psychological problems, there was a possibility of learned behavior and symptom magnification. (Exs. 27-3, -4, 36-10, -11).

We are not persuaded by Dr. Button's analysis. Dr. Button's observation regarding the incidence of CTS in operating room personnel is relevant, but does not persuasively answer the question of whether claimant's CTS is work-related. Furthermore, we have found nothing in the record to suggest that either claimant's status as a registered nurse or her psychological condition resulted in any learned or functional behavior. Indeed, Button himself admitted that he had observed no overt psychological problems and discerned no secondary gain factors during his examination of claimant. (Ex. 36-10). Because Dr. Button's opinions are predicated on questionable analysis, we give those opinions minimal probative weight. Furthermore, we also give minimal weight to the reports of those physicians who concurred with Dr. Button.

For these reasons, we affirm the Referee's decision setting aside the insurer's denial of claimant's bilateral CTS claim.

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 is $1,000, to be paid by the insurer. In reaching this conclusion, we have 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 3, 1994 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
HARVEY L. YARBOROUGH, Claimant
WCB Case No. 93-02194
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Michael V. Johnson's order that declined to grant permanent total disability. On review, the issue is entitlement to permanent total disability.

We adopt and affirm the Referee's order, except for his finding that claimant's preexisting physical conditions were not disabling on the date of injury, and provide the following supplementation.

In 1970, claimant was thrown from a truck and injured his low back. That claim was closed on July 8, 1971, with an award of 15 percent (48 degrees) unscheduled permanent disability. (Ex. D). In 1980, claimant's right leg was extensively damaged by heavy machinery. This claim was closed on September 8, 1982, with two awards: (1) 35 percent (52.50 degrees) scheduled permanent disability for his right leg; and (2) 25 percent (80 degrees) unscheduled permanent disability for further injury to claimant's back. (Ex. R).

On April 6, 1988, while working as a truck driver, claimant was involved in a truck wreck and sustained injuries to his head (i.e., closed head injury with loss of consciousness), low back, left leg and shoulder; claimant immediately began to experience loss of memory and concentration secondary to this head injury. (Exs. 2 & 3). Although claimant filed an injury claim, (Ex. 1e), the record does not reveal whether claimant received any further award of permanent disability resulting from this accident. Claimant was subsequently involved in another truck accident on July 11, 1988; claimant suffered multiple contusions, abrasions, and a head laceration. (Ex. 9-1). The claim was accepted for contusions of the left leg, head and right shoulder. (Ex. 13).

Claimant asserts that he is permanently totally disabled as a result of the July 1988 injury. Finding that the medical evidence alone was insufficient to sustain an award of permanent total disability, the Referee analyzed the claim under the "odd lot" doctrine. In determining that claimant was not permanently totally disabled, the Referee concluded that claimant's preexisting physical and mental conditions were not disabling at the time of his July 1988 injury and, therefore, the Referee did not consider them.

In the context of permanent total disability, we consider the extent of claimant's total impairment, including that caused by all disabling conditions, regardless of compensability, that preexisted the injury and the impairment resulting from the injury itself. Elder v. Rosboro Lumber Co., 106 Or App 16, 19 (1991); Weyerhaeuser Co. v. Rees, 85 Or App 325, 329 (1987).

The record shows that, following the 1980 injury, claimant's then-treating physician placed restrictions on claimant's work activities. (Ex. 2-4). A December 1983 report provided similar findings. (Ex. CC). Although claimant subsequently completed vocational training and obtained full-time work maintaining heavy equipment, there is no evidence that the restrictions were thereafter reduced or eliminated. Based on such evidence, we conclude that claimant had preexisting physical disabilities at the time of his July 1988 injury. Therefore, those physical disabilities should be considered in determining permanent total disability.

Nonetheless, we agree with the Referee that claimant did not prove permanent total disability. The only evidence presented by claimant showing that he was permanently and totally disabled was the testimony of Mr. McNaught, a vocational counselor. Mr. McNaught's opinion was partially based on the premise that claimant was disabled by mental and emotional conditions. There is some evidence in the record showing that, due to his April 1988 closed head injury, claimant is disabled from emotional problems and loss of memory. (Exs. 29A-2, 35-8, 36-2). However, we find an absence of evidence that such conditions were disabling at the time of the July 1988 injury. Thus, we agree with the Referee that claimant's emotional and mental conditions should not be considered, and because Mr. McNaught relied upon such conditions, we find that his opinion is not persuasive.

Furthermore, there was persuasive testimony from Mr. Rau, who provided optional vocational services for claimant, that claimant was capable of performing some jobs, despite his preexisting disabilities and the disability caused by the July 1988 injury. Accordingly, we conclude that claimant did not prove he is permanently and totally disabled.

ORDER

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

November 30, 1994 Cite as 46 Van Natta 2422 (1994)

In the Matter of the Compensation of
ROBERT E. CROSSE, Claimant
WCB Case No. 93-00089
ORDER ON RECONSIDERATION
Ronald A. Fontana, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

The self-insured employer requests, and claimant cross-requests, reconsideration of our November 4, 1994 Order on Review. In that order, we found claimant's major depression claim compensable and awarded attorney fees. In its motion, the employer expresses confusion concerning the attorney fee award and requests clarification. Claimant asserts that he is entitled to attorney fee awards in greater amounts than awarded by our order.

Before hearing, the employer accepted a claim for adjustment disorder. The Referee found that claimant did not prove a claim for major depression but awarded an assessed fee of $3,000 for claimant's attorney services in obtaining the pre-hearing rescission of the denial for adjustment disorder.

On review, we agreed with claimant that he proved a claim for major depression. Since claimant finally prevailed from the denial of major depression, we awarded claimant's attorney an assessed fee of $3,000 for services at hearing and on review regarding the major depression issue. See ORS 656.386(1). Furthermore, we affirmed the Referee's award of $3,000 for claimant's attorney's services regarding the pre-hearing rescission of the adjustment disorder, finding such amount to be reasonable. Therefore, pursuant to our order, claimant's attorney to date has been awarded $3,000 for pre-hearing services regarding the adjustment disorder and $3,000 for services at hearing and on review regarding the major depression.

We do not agree with claimant's assertion that he is entitled to a total attorney fee award of $13,195. Based on the reasoning in our Order on Review and after considering the employer's objections, we continue to find that the attorney fees awarded on review are reasonable.

Accordingly, we withdraw our November 4, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our November 4, 1994 order. The parties' rights of appeal shall begin to run on the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WAYNE L. DUVAL, Claimant
WCB Case No. 93-06091
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Gary K. Jensen, Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Baker's order which upheld the insurer's denial of claimant's current left knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt and affirm the Referee's findings of fact, with the following correction and supplementation. At the time of claim acceptance for the March 1977 compensable left knee injury claim, the employer had no knowledge or notice of claimant's preexisting degenerative arthritis.

In August 1977, claimant saw Dr. Schachner for complaints of medial joint line discomfort, which Dr. Schachner believed were related to the underlying arthritis.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish the compensability of his current left knee degenerative arthritic condition and need for treatment as a resultant condition under ORS 656.005(7)(a)(B). Claimant contends that a January 1978 Determination Order closing a March 1977 left knee injury claim was based in part on degenerative arthritis and, therefore, that the insurer's failure to contest the permanent disability award constituted an acceptance of the degenerative arthritis. We conclude that the insurer is barred by claim preclusion from denying that claimant's left knee degenerative arthritis is part of claimant's March 1977 compensable claim.

Claimant injured his left knee at work in March 1977. Claimant filed an "801" form for a left knee injury. Dr. Schachner diagnosed a torn posterior horn of the left medial meniscus. He discovered the degenerative arthritis during a June 6, 1977 surgery to repair the torn meniscus. The insurer accepted the left knee claim on June 9, 1977. The insurer did not learn of the degenerative arthritis until after it accepted the left knee claim.[1]

At the time of claim acceptance, Dr. Schachner indicated that claimant's symptoms were due to the torn meniscus. Thereafter, in August 1977, claimant saw Dr. Schachner for complaints of medial joint line discomfort; Dr. Schachner believed that those complaints were related to claimant's underlying arthritis. (Ex. 7-1).

In a November 30, 1977 closing examination report, Dr. Schachner concluded that claimant's symptoms related to the meniscectomy had resolved and that any residual symptoms were related to the underlying degenerative arthritis. (Id.) Dr. Schachner then advised that the "claim may be closed having no evidence of any residua from the meniscal tear and arthrotomy but demonstrating residua from the underlying preexisting arthritis which the injury historically aggravated as he reports no preexisting symptoms prior to the injury." (Id.; emphasis added).

Thereafter, a January 1978 Determination Order awarded claimant 22.5 degrees (15 percent) permanent disability for "loss of [his] left leg." (Ex. 8). No one appealed the Determination Order. Claimant did not seek treatment for his left knee again until early 1993, at which time Dr. Carter recommended a total knee arthroplasty for claimant's advanced degenerative arthritis.

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[1] The record does not establish when the insurer received Dr. Schachner's operative report. However, Dr. Schachner's June 6, 1977 operative report indicates that it was not transcribed/dictated until the afternoon of June 8, 1977. Thus, we find it unlikely that the insurer had received that report at the time it issued its claim acceptance.

At hearing, claimant argued, inter alia, that the insurer's failure to contest the Determination Order operated as an acceptance of the degenerative arthritis. The Referee rejected that argument on the ground that there had been no litigation finding that the degenerative arthritis was the basis for the disability benefits awarded by the Determination Order.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). There, the carrier accepted a claim that had been diagnosed as thoraco-cervical strain and myofascitis. After the claimant's physician diagnosed cervical degenerative disc disease, the carrier neither accepted nor denied the condition; it did, however, authorize surgery for it. A Determination Order thereafter awarded permanent partial disability based in part on the effects of the surgery for the degenerative disc disease. After the claimant's neck pain subsequently worsened, the claimant's physician requested authorization to perform additional cervical surgery. The carrier denied the compensability of the cervical condition. The claimant appealed, arguing, inter alia, that the carrier's failure to seek review of the Determination Order barred it from then denying the compensability of the worsening of the degenerative condition.

We concluded that the carrier was not precluded from denying the compensability of claimant's aggravation claim, on the ground that neither the carrier's approval of surgery nor its failure to challenge the Determination Order constituted an acceptance of the claimant's degenerative neck condition. Richard J. Messmer, 45 Van Natta 874 (1993). The Court of Appeals disagreed with us. Citing Hammon State Line v. Stinson, 123 Or App 418 (1993), the court stated that an award made by a Determination Order is based on certain underlying facts, one of which is the scope of the compensable claim. Therefore, it reasoned, claim preclusion bars a carrier from later arguing that the condition for which an award was made is not part of the compensable claim. 130 Or App at 258.

Applying that analysis to the facts, the Messmer court concluded that, although the carrier's payment of compensation did not, by itself, constitute an acceptance of claimant's cervical degenerative condition, ORS 656.262(9), its failure to challenge the award on the ground that it included an award for a noncompensable condition precluded it from denying that the cervical degenerative condition was part of the compensable claim. Id. The court concluded that the result was not that the carrier had accepted the degenerative condition; rather, it was that the carrier was barred by claim preclusion from denying that that condition was part of the claimant's compensable claim. Id.

We reach the same conclusion in this case. The condition at issue is claimant's left knee degenerative arthritis. The insurer has never formally accepted or denied that specific condition. However, claimant consulted Dr. Schachner in August 1977 for complaints of discomfort that Schachner related to degenerative arthritis.[2] Furthermore, the medical evidence at the time of closure of claimant's 1977 left knee claim in January 1978 reveals that the symptoms related to claimant's meniscal tear and ensuing surgery had resolved; only claimant's preexisting degenerative arthritis continued to cause any symptoms. Under the circumstances, we conclude that the January 1978 Determination Order necessarily was based in part, if not whole, on the degenerative arthritis. That Determination Order became final by operation of law. Therefore, we conclude that, under Messmer, the insurer's failure to challenge the January 1978 award on the ground that it included an award for a noncompensable condition, viz., the preexisting degenerative arthritis, precludes it from denying that that condition was part of the March 1977 compensable claim.

The result is not that the insurer has accepted claimant's left knee degenerative arthritis; rather, it is that the insurer is barred by claim preclusion from denying that it is part of claimant's November 1980 claim. Messmer, supra, 130 Or App at 258. Accordingly, for these reasons, we reverse the Referee's decision upholding the insurer's denial of claimant's current left knee condition.

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[2] There is no direct evidence regarding whether the insurer paid for the services in August 1977 related to the degenerative arthritis. Regardless of whether the insurer paid for those services, however, we conclude that, under Messmer, the critical inquiry is whether claimant received treatment for the degenerative arthritis sometime before claim closure. On this record, we conclude that the answer is "yes." (See Ex. 7-1).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). 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 is $3,500, to be paid by the insurer. In reaching this conclusion, we have considered the time devoted to this case (as represented by the record and claimant's appellant's and reply 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 March 11, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by the insurer.

In the Matter of the Compensation of
VERDA K. HARMON, Claimant
WCB Case No. 92-11747
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our November 2, 1994 Order on Review. In that order, we: (1) admitted certain "post-reconsideration" medical reports; (2) affirmed the Referee's award of 20 percent (64 degrees) unscheduled permanent disability for a cervical and right shoulder condition; and (3) authorized SAIF to offset temporary disability compensation paid after May 15, 1991, against claimant's present or future permanent disability awards in this claim.

In its motion for reconsideration, SAIF asserts that the bankruptcy court has issued a declaratory judgment barring SAIF from recovering any overpayment of workers' compensation benefits from claimant's present or future permanent disability awards in this claim. SAIF further asserts that it has moved the bankruptcy court for a stay of judgment pending appeal. On reconsideration, SAIF requests that we abate our November 2, 1994 order pending resolution of its appeal in the bankruptcy matter. SAIF argues that, under the bankruptcy court's ruling, it will be precluded from recovering the overpayment, despite the Board's authorization to do so. Claimant has submitted a response in opposition to SAIF's motion.

SAIF cites Dale A. Karstetter, 46 Van Natta 977 (1994), and Richard N. Wigert, 46 Van Natta 486 (1994), in support of its argument that the Board may abate its order pending appeal of the bankruptcy decision. However, those cases are distinguishable because they involved related issues in other workers' compensation proceedings. The present case, by contrast, involves a wholely unrelated bankruptcy proceeding before a different forum. Accordingly, the cases cited by SAIF are inapposite.

Moreover, the bankruptcy decision and SAIF's pending appeal of that decision were events which were in existence at the time of SAIF's request for Board review. Although SAIF's motion for postponement was denied by the Referee, SAIF did not seek postponement of Board review or delay of our decision. Instead, SAIF registered its request only after issuance of our order. In light of such circumstances, we are not inclined to address SAIF's postponement request at this late date.

In any event, our function as an adjudicative body is to resolve workers' compensation disputes brought to us by the litigants. Here, we have served that function and have issued an order which has resolved the workers' compensation dispute. Although we acknowledge SAIF's predicament, we have concluded our review of this case and have granted the relief that we are authorized to grant. The bankruptcy court proceedings are separate proceedings in a different forum and are outside of our control. It is unknown what the final outcome of the bankruptcy court will be or how long it will take to finally resolve the bankruptcy dispute. Under such circumstances, we decline to hold this matter in abeyance indefinitely pending resolution of the unrelated bankruptcy matter.

Accordingly, our November 2, 1994 order is withdrawn. On reconsideration, as supplemented herein, we republish our November 2, 1994 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 30, 1994 Cite as 46 Van Natta 2426 (1994)

In the Matter of the Compensation of
ALLAN R. ROEDER, Claimant
WCB Case No. 93-11303
ORDER ON RECONSIDERATION
Galton, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

On October 11, 1994, we withdrew our September 20, 1994 order that: (1) concluded that the SAIF Corporation's denial of claimant's neck and right arm complaints was not barred by claim or issue preclusion; (2) upheld SAIF's denial; and (3) reversed the Referee's assessment of a penalty and attorney fee. We took this action to consider claimant's motion for reconsideration. Having received the parties' respective positions, we proceed with our reconsideration.

Compensability

On reconsideration, claimant argues that we erred in our determination of claim and issue preclusion and compensability. For the following reasons, we adhere to our prior conclusion.

We briefly summarize the procedural history of the case. Claimant sustained a compensable C5-C6 disk herniation while working for SAIF's insured in July 1990. Claimant has severe degenerative disk disease in the cervical spine which preexisted the 1990 injury. The 1990 injury claim was closed in February 1991. In late 1992, claimant began experiencing increased neck and right arm symptoms. On April 9, 1993, SAIF issued a current condition/aggravation denial and responsibility disclaimer.

Claimant challenged the denial and a hearing was held before Referee Crumme. Referee Crumme found that a claim had not been filed for the current neck and right arm symptoms, and that SAIF's denial was premature. The Board has affirmed Referee Crumme's decision. Allan R. Roeder, 46 Van Natta 1671 (1994) ("Allan R. Roeder I").

Subsequent to issuing the April 9, 1993 denial, SAIF received numerous medical billings for treatment for claimant's neck and right arm complaints. After receiving these billings, SAIF issued a second aggravation/current condition denial and responsibility disclaimer on September 22, 1993, and an amended denial and disclaimer on October 28, 1993. Claimant requested another hearing.

In the present case, Referee Livesley concluded that the prior litigation before Referee Crumme operated as a res judicata bar to the September and October 1993 denials. On review, we disagreed. We held that the merits of claimant's current neck and right arm condition were not litigated in the prior proceeding before Referee Crumme (Allan R. Roeder I). That litigation, instead, established that no claim had been filed for claimant's current condition. We concluded that the denials were not barred by claim or issue preclusion.

On reconsideration, claimant contends that the Board failed to identify what event constituted a new and different claim or issue separate from the issues adjudicated before Referee Crumme. Relying on Drews v. EBI Companies, 310 Or 134 (1990), claimant argues that anything which was or could have been litigated before Referee Crumme was precluded from later adjudication.

The term res judicata comprises two doctrines, claim preclusion and issue preclusion. Drews v. EBI Companies, supra; North Clackamas School Dist. v. White, 305 Or 48, mod 305 Or 468 (1988). Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. White,

supra. Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980). Claim preclusion does not require actual litigation, but it does require the opportunity to litigate, whether or not used. Drews, supra.

In the first proceeding before Referee Crumme, we affirmed Referee Crumme's conclusion that no claim had been made and, therefore, SAIF's denial of claimant's claim for current neck and right arm complaints was premature. Allan R. Roeder I, supra. Because of that holding, the parties had no opportunity to litigate the issue of compensability. The compensability of the claim was not, and could not have been, litigated in that proceeding. Therefore, no finality attached to the compensability issue and it is not barred by claim preclusion. Similarly, because the issue of compensability was not actually litigated, it is not barred by issue preclusion.

Claimant argues that our holding that the medical evidence does not establish compensability is inconsistent with our previous decision. We disagree. The issue at the first proceeding was whether a claim had been filed. Allan R. Roeder I, supra. In the present case, the issue concerns the merits, i.e., whether the claim is compensable. We see no inconsistency between the two issues because they are entirely separate.

Remand

Claimant contends that we failed to address his alternative argument that his medical services were compensable diagnostic services. In Allan R. Roeder I, supra, without specifying which particular diagnostic services were compensable, claimant argued that "all" of the medical services were diagnostic and compensable. In determining that the prior "claim" was premature, we noted that there was no indication in the record that there was a diagnostic service dispute. Id.

On reconsideration in this case (Allan R. Roeder II), we requested supplemental briefing from the parties to assist us in clarifying which services claimant is contending are compensable diagnostic services. We admonished the parties to confine their arguments to the record in this case presently before the Board.

Claimant contends that the record is insufficiently developed for him to adequately address this issue. He notes that the medical reports do not correspond to the bills in the record and it is unclear whether the bills have been paid by SAIF or whether SAIF is even disputing the charges. Claimant asks us to remand to the Referee to clarify what charges SAIF is denying and for the submission of relevant medical reports that would correspond to the billings.

SAIF argues that claimant has failed to prove that any of the medical procedures are compensable as diagnostic medical services. SAIF also contends that remand is not warranted because claimant has simply failed to carry his burden of proof.

We may remand a case to the Referee if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the referee. 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).

Claimant has not explained why the record is insufficiently developed. Moreover, claimant provides no explanation why evidence regarding his medical services was unobtainable with due diligence at the time of the hearing. Therefore, we deny claimant's request for remand.

In conclusion, as supplemented herein, we adhere to and republish our September 20, 1994 Order On Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILLY L. LEMONS, Claimant
WCB Case No. C4-02757
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On October 31, 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.

Here, claimant's former attorney has filed a notice of lien seeking a portion of the CDA proceeds as payment for services rendered during negotiations which preceded this agreement. Claimant's former counsel has specified that he would be willing to reduce his fee by $500, in view of the fact that former counsel's office would not be required to expend administrative costs of processing the CDA.

In response, claimant raises no objection to his former counsel's request, provided that the CDA "of $70,000 is the agreed settlement," and "as long as they (the attorney fees) are the same as agreed to in (the) CDA agreement of $8,875." Inasmuch as the proposed settlement matches the conditions set forth in claimant's response, we conclude that claimant agrees that his former counsel is entitled to an attorney fee from the CDA proceeds.

When a CDA is approved under the provisions of ORS 656.235 and OAR 438-09-020, an attorney fee may be approved by the Board in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of any amount of the proceeds in excess of $12,500. See OAR 438-15-052. Consequently, 25 percent of the first $12,500 of the agreement proceeds is $3,125. 10 percent of the amount of the proceeds in excess of $12,500 is $5,750 ($70,000 - $12,500). Therefore, the maximum fee claimant's counsel is entitled to under the CDA rules is $8,875 ($3,125 + $5,750). After reducing the fee by the $500 amount agreed to by claimant's former counsel (based on there being no further services required in order to process the CDA), we conclude that claimant's counsel is entitled to $8,375 of the $70,000 in settlement proceeds.

Accordingly, we conclude that the parties' agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 438-15-052(1). An attorney fee of $8,375, payable to claimant's counsel, is also approved. OAR 438-15-052. SAIF is directed to distribute $8,375 of the CDA proceeds directly to claimant's counsel, with the remaining $61,625 going directly to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD D. CLOUD, Claimant
WCB Case Nos. 93-09600 & 93-08668
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Baker's order which: (1) set aside its denial of claimant's medical services claim for his current cervical condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. In its respondent's brief, SAIF challenges the Referee's attorney fee award to claimant's counsel for clarifying SAIF's "overbroad" denial of other conditions not claimed. Claimant moves to strike SAIF's respondent's brief, contending that it has untimely raised the attorney fee issue. On review, the issues are motion to strike, compensability, responsibility, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

We adopt and affirm the Referee's reasoning and conclusions on these issues.

Motion to Strike

Claimant has moved to strike SAIF's respondent's brief on the grounds that it is untimely, in violation of proper appellate procedures and addresses an issue not previously raised. We disagree with claimant's contentions.

SAIF was a party to the hearing, as well as to the Referee's order. Thus, it is a "party" on review of the Referee's order. See Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992). Although SAIF did not appeal or cross-request review of the Referee's order, it may raise additional issues not addressed by the appellant, notwithstanding the lack of a cross-appeal, as long as the appellant has not withdrawn its request for review. See Shirley S. Scaparro, 44 Van Natta 1099, 1100 (1992); Jimmie Parkerson, 35 Van Natta 1247, 1249 (1983). Inasmuch as Liberty has not withdrawn its request for review of the Referee's order, we consider SAIF's contentions regarding the Referee's attorney fee award and deny claimant's motion to strike.

Attorney Fee

On review, SAIF contends that the Referee erred in awarding an attorney fee under ORS 656.386(1) because claimant did not prevail finally against the conditions listed in its denial. We agree.

Claimant sustained a compensable cervical injury in 1987, for which Liberty was responsible. In April 1993, while SAIF was on the risk, claimant experienced neck pain radiating into the shoulders. Claimant's treating physician, Dr. Polo, wrote Liberty requesting that claimant's original claim be reopened.

On May 27, 1993, Liberty denied and disclaimed responsibility, listing SAIF as the responsible insurer. The employer completed two form 801's (which claimant did not sign) and sent them to SAIF for processing. One referred to a neck injury on April 26, 1993 and the other referenced the 1987 injury and listed head, neck, shoulders, back and leg as the affected body parts. (Exs. 21, 22). SAIF later disclaimed responsibility after receiving claimant's "neck" claim. (Ex. 23). In its subsequent denial of compensability and responsibility, however, SAIF listed the denied conditions as head laceration, cervical strain, thoracic strain, cervical degenerative disc disease, lumbar degenerative disc disease, and bilateral shoulder pain. (Ex. 26).

At hearing, claimant's counsel stated that the claim was only for claimant's cervical condition and that there was no claim being made for the other conditions listed in SAIF's denial. (Tr. 8). Upholding SAIF's denial on the merits and finding Liberty responsible for claimant's current cervical condition, the Referee, nevertheless, set aside those portions of SAIF's denial which pertained to the "unclaimed" conditions. The Referee also awarded claimant's counsel an attorney fee for clarification of SAIF's "overbroad" denial.

Based on our de novo review of the record, we conclude that SAIF's denial was not "overbroad" when issued, since the claim forms the employer submitted on claimant's behalf (one of which listed body parts other than claimant's neck) constituted a "claim." See ORS 656.005(6). Given that claimant's attorney expressly represented at hearing that the only "claim" being made was for claimant's cervical condition, we find, however, that claimant effectively withdrew his claim for the other conditions listed in SAIF's denial. Therefore, the only claim asserted was for claimant's cervical spine, for which SAIF's denial was upheld.

Moreover, inasmuch as claimant acknowledged that he was not seeking compensation for the other conditions listed in SAIF's denial, claimant has not finally prevailed with respect to a denial of a claim for compensation pursuant to ORS 656.386(1). See Calvin E. Bigelow, 45 Van Natta 1577, 1578 (1993) (Where the claimant acknowledged that he was not seeking compensation for a denied condition, he would not have prevailed against a denial of a claim for compensation). Consequently, no attorney fee is warranted. Id.

Claimant's citations to Ronald R. Willard, 45 Van Natta 937 (1993), Marsha K. Flanary, 44 Van Natta 393 (1992), and Mickey L. Wood, 40 Van Natta 1860 (1988), do not change the result. In each of those cases, an attorney fee was awarded for "clarification" of an "overbroad" or inartfully phrased denial. However, in each of those cases, there was an accepted claim with the carrier responsible for the attorney fee award. In contrast, here, claimant has no accepted claim with SAIF. Where claimant has no accepted claim with the carrier allegedly responsible for payment of an attorney fee under ORS 656.386(1), he cannot prevail finally with respect to a denial of a claim for compensation. Thus, the Referee erred in awarding claimant an attorney fee for clarifying SAIF's "overbroad" denial.

Claimant's counsel is, however, entitled to an attorney fee for services on review concerning Liberty's appeal. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable 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 the case (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services devoted to the motion to strike and attorney fee issues.

ORDER

The Referee's order dated May 3, 1994 is affirmed in part and reversed in part. That portion of the order which awarded claimant's counsel a $600 attorney fee for clarifying SAIF's denial is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by Liberty.

In the Matter of the Compensation of
ROBERT L. COMPTON, Claimant
WCB Case No. 93-14386
ORDER ON REVIEW
Dale L. Smith, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Nelson.

The insurer requests review of Referee Davis' order which awarded claimant temporary partial disability after July 15, 1993. On review, the issue is temporary disability.

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

At the outset, we make the following corrections in the Referee's order. Claimant initially saw Dr. Carpenter on May 14, 1993, not March 14, 1993. Second, claimant was discharged from his employment on April 21, 1993, not April 20, 1993.

Turning to the merits, the insurer contends that the Referee erred in awarding claimant additional temporary partial disability after July 15, 1993, the date it stopped payment of temporary disability. The insurer asserts that claimant ceased to be a worker after he was discharged for reasons unrelated to his injury. We disagree.

Claimant sustained a left shoulder injury on April 16, 1993. His claim was initially denied on July 26, 1993, but was later accepted on November 12, 1993. After claimant was released to return to regular work on April 19, 1993, he was discharged from his employment on April 21, 1993 because of unexcused absences from work. Claimant subsequently consulted Dr. Carpenter on May 14, 1993, who would later declare claimant not medically stationary and limit him to modified work on June 4, 1993. (Ex. 8).

Although the insurer argues that claimant ceased to be a member of the work force after his discharge from employment for reasons unrelated to his injury, claimant testified that he continued to seek employment. (Trs. 16, 33). Given claimant's unrebutted testimony, we find that claimant was willing to work and was making reasonable efforts to find work after his discharge. Thus, we conclude that claimant was still in the work force after his discharge on April 21, 1993. Cf. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989) (claimant in work force for purposes of aggravation claim when willing to work and making reasonable efforts to obtain employment).

The Referee determined that claimant was entitled to temporary partial disability after July 15, 1993 because Dr. Carpenter restricted claimant to light duty on June 4, 1993. Reasoning that such restrictions required that the insurer consider claimant's diminution in earning power in "any kind of work," the Referee ordered the insurer to apply temporary OAR 436-60-030. See Stone v. Whittier Wood Products, 124 Or App 117 (1993).

We agree with the Referee's reasoning. The insurer asserts, however, that claimant's medical condition did not change after his release to regular work. Therefore, it argues that claimant was not entitled to temporary disability after claimant received his full work release, even though it continued to pay temporary disability until July 15, 1993. We disagree.

Notwithstanding claimant's testimony that his medical condition did not change after his release to full duty, we, nevertheless, conclude that claimant is still entitled to temporary disability. Claimant is not required to prove a worsening of his condition in order to receive temporary disability prior to claim closure. See Rodgers v. Weyerhaeuser, 88 Or App 458, 460 (1987). Claimant must only show that he was not medically stationary, i.e., that material improvement was expected with treatment or the passage of time. See ORS 656.005(17); Jimmie G. Clark, 45 Van Natta 2308, 2310 (1993).

Based on our de novo review of the record, claimant was not medically stationary when temporary disability was terminated on July 15, 1993. Dr. Fulper, who initially treated claimant on April 16, 1993, never declared claimant medically stationary. Dr. Carpenter specifically stated that claimant was not medically stationary on June 4, 1993 and provided injection treatment for claimant's left shoulder. In addition, an examining physician, Dr. Duff, concluded in October 1993 that claimant was not medically stationary with respect to his April 16, 1993 injury and that there was potential for further improvement in claimant's left shoulder condition with additional treatment. (Ex. 14-4).

Finally, the insurer contends that Dr. Carpenter's work restrictions are of no effect because he was not claimant's attending physician. However, the record is clear that Dr. Carpenter was primarily responsible for treatment of claimant's compensable condition in June 1993, when he restricted claimant to modified work. See ORS 656.005(12)(b). Thus, we find that Dr. Carpenter was the attending physician when he imposed work restrictions on claimant.

In conclusion, we agree with the Referee that claimant was entitled to a calculation of his temporary partial disability pursuant to temporary OAR 436-60-030. Thus, we affirm the Referee's decision on this issue. We note that, since claimant did not file a brief on review, claimant's counsel is not entitled to an attorney fee pursuant to ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The Referee's order dated May 11, 1994 is affirmed.

December 7, 1994 Cite as 46 Van Natta 2432 (1994)

In the Matter of the Compensation of
GERALD F. LICHT, Claimant
WCB Case No. 93-04648
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's injury claim for a herniated disc condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a punch press operator, sustained an injury while working for SAIF's insured on September 2, 1992, when a tube that he was bending broke, causing him to fall back on his left hip. (Ex. 4). When claimant was seen at the emergency room, he had pain in his leg and back. (Ex. 2).

SAIF issued a denial on November 25, 1992, which referred to the claim as "a claim for an alleged injury to your left hip." (Ex. 6). SAIF denied the claim on the ground that there were no objective medical findings to determine a diagnosable condition. However, SAIF agreed to pay claimant's medical expenses, on a diagnostic basis, for services rendered on September 2, 1992. On April 16, 1993, claimant requested a hearing on compensability.

On January 25, 1993, claimant was referred to Dr. Corson, an orthopedic surgeon. Dr. Corson found that claimant had a large disc rupture at the L4-5 level. (Exs. 7-10).

On June 7, 1993, SAIF issued an "amended" denial, which stated that claimant had modified his claim to include a herniated disc at L4-5. (Ex. 12). SAIF denied the claim on the basis that claimant's employment was not the compensable cause in the development or worsening of his herniated disc at L4-5. On June 9, 1993, claimant requested a hearing on the June 7, 1993 "amended" denial.

CONCLUSIONS OF LAW AND OPINION

Scope of the Denial

The Referee concluded that claimant's failure to timely appeal SAIF's November 25, 1992 denial precluded him from litigating the compensability of his herniated disc. The Referee characterized SAIF's November 25, 1992 denial as one that "denied that an injury occurred on September 2, 1992."

Claimant argues that SAIF's November 25, 1992 denial referred only to a claim for a left hip injury. He contends that SAIF's denial of a left hip injury does not preclude him from litigating a second denial for a herniated disc.

SAIF argues that its November 25, 1992 denial was more than a denial of a hip condition. SAIF asserts that, although the denial letter mentioned only the left hip, the letter stated that SAIF was denying his "claim" and, according to the Form 827, the claim encompassed an injury for both the left hip and the low back. According to SAIF, the Board must look behind the denial letter to determine what the claim encompasses. We disagree.

SAIF's November 25, 1992 denial stated, in part: "You filed a claim for an alleged injury to your left hip, which occurred on or about September 2, 1992, while employed with [the employer.]" (Ex. 6). The denial referred only to an injury to claimant's left hip and made no mention of claimant's back pain, notwithstanding that the Form 827 referred to "low back and hip pain." (Ex. 5). SAIF's "amended denial" on June 7, 1993, also characterized claimant's initial claim as "an injury to your left hip" and said that claimant "modified" his claim to include a herniated disc at L4-5. (Ex. 12).

In Arthur D. Esgate, 44 Van Natta 875 (1992), the carrier had denied the claimant's occupational disease claim for a right hand condition on July 23, 1990. The denial was never appealed and became final by operation of law. The claimant refiled the claim on October 11, 1990 and the carrier issued an "amended" denial on October 24, 1990. The carrier argued that claim preclusion barred the claimant's October 1990 claim for the same condition that was denied in July 1990. We agreed with the carrier, reasoning that the claimant's present claim was for the identical condition that was denied by the July 23, 1990 denial. Furthermore, there was no evidence that the claimant's condition had changed since July 23, 1990.

Here, unlike in Arthur D. Esgate, supra, claimant's present claim is for a herniated disc, a different condition than the left hip injury that SAIF denied on November 25, 1992. Moreover, claimant was not even aware that he had a herniated disc until February 1993.

The express language of the denial controls the scope of the conditions denied. See Tattoo v. Barrett Business Service, 118 Or App 348 (1993). We conclude that SAIF's November 25, 1992 denial was expressly limited to claimant's left hip injury and did not include his claim for a herniated disc. Consequently, claimant's herniated disc claim is not barred by his failure to timely appeal SAIF's November 25, 1992 denial. We proceed to review the merits of the claim.

Compensability

Claimant relies on the opinion of his treating physician, Dr. Corson, to support his claim of compensability. SAIF relies on the opinion of Dr. Dickerman to dispute the claim. Both physicians agree that claimant has significant preexisting degenerative disease. Dr. Corson reported in January 1993 that claimant has "quite advanced lumbar spondylosis with a degenerative scoliosis and a true isthmic L5 spondylolisthesis, secondary to the bilateral spondylolysis of L5." (Ex. 7). Dr. Corson also thought that claimant had significant spinal stenosis. Subsequent tests revealed that claimant had a large disc rupture at the L4-5 level. (Ex. 10).

Under ORS 656.005(7)(a)(B), when the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, the injury is compensable only if it is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594, rev den 318 Or 27 (1993).

Claimant was referred to Dr. Corson in January 1993, more than four months after the September 2, 1992 injury. In February 1993, Dr. Corson reported that "since [claimant's] symptoms of back discomfort have come on and have been persistent since the fall that he sustained in September of 1992, I would feel that it is most likely that this caused the disc rupture." (Ex. 10).

In October 1993, claimant's attorney prepared a summary of a conversation with Dr. Corson. Dr. Corson reiterated his opinion that claimant's industrial accident of September 2, 1992 was the most likely cause of his L4-5 disc rupture. (Ex. 15). Although Dr. Corson could not state absolutely that the

injury caused the disc rupture, he believed that it was "likely because [claimant] would probably have been symptomatic prior to the fall if he had a ruptured disc." (Id). Dr. Corson believed "within a reasonable degree of medical probability that the major contributing cause of [claimant's] disability and need for medical treatment since September 2, 1992 has been his industrial accident of that date." (Id).

Where the medical evidence is divided, we rely on those opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259 (1986). In addition, we tend to give greater weight to the opinion of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Corson's opinion.

We find that Dr. Corson's opinion concerning the causation of claimant's condition is conclusory and is based on an incomplete history. Dr. Corson failed to address the relationship between claimant's preexisting disease and the herniated disc, except to say that claimant's fall at work "probably worsened" claimant's underlying degenerative disc disease and made his spondylolisthesis symptomatic. (Ex. 15). We do not find Dr. Corson's opinion persuasive because there is no indication that he was familiar with claimant's previous medical history.

In contrast, Dr. Dickerman reviewed claimant's medical records from 1972 to 1993 and reported that claimant had a multi-year, slowly progressive history of involvement of the lower extremities that had progressed more recently, but predated the September 1992 industrial injury. (Ex. 11). Dr. Dickerman concluded that claimant's herniated disc was not the result of the industrial injury. Rather, claimant's symptoms were due to progression of the very severe, underlying multi-level lumbar degenerative disease. (Id). Dr. Dickerman opined that there was reason to believe that claimant's current symptoms were not related to the herniated disc, but were instead related to his preexisting disease. At a deposition, Dr. Dickerman testified that claimant's symptoms were indicative of the preexisting spinal stenosis. (Ex. 14-10).

Furthermore, we do not find that Dr. Corson's opinion that claimant's symptoms of back discomfort came on and had been persistent since the fall in September 1992 to be persuasive because it conflicts with other evidence in the record. (Ex. 10). Although the medical records indicate that claimant had pain in his leg and back after the injury, claimant testified that he returned to work the day after the injury and had no time loss as a result of the injury. Dr. Dickerman reported that claimant specifically denied having any significant symptoms into the lower extremities immediately following the accident, although he did experience intermittent discomfort in the low back. (Ex. 11). Dr. Dickerman reported that claimant began to have symptoms in his lower extremities toward the end of November 1992, more than two months after the injury.

We conclude that Dr. Corson's opinion is not persuasive because it is conclusory and is based on an incomplete history. There is no other medical evidence to establish that claimant's industrial injury was the major contributing cause of his herniated disc. Consequently, we conclude that claimant has failed to establish that his herniated disc is compensable.

ORDER

The Referee's order dated February 4, 1994 is affirmed.

In the Matter of the Compensation of
CHARLES A. O'NEIL, Claimant
WCB Case No. 93-07000
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Hazelett's order that declined to award an assessed fee under ORS 656.382(1) for obtaining a Director's order that set aside the insurer's notice of ineligibility for vocational assistance. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not his ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

In August 1992, claimant fell from a ladder at work. The insurer accepted claims for L-1 fracture, left hip fracture, and left wrist fracture. In January 1993, the vocational rehabilitation counselor assigned to assess claimant's eligibility for vocational assistance placed his claim in "pending" status. In March 1993, claimant's counsel objected to holding claimant's eligibility in "pending" status, and requested that the insurer determine eligibility. On June 17, 1993, the insurer issued a "Notice of Ineligibility for Vocational Assistance" on the ground that claimant did not have "a substantial handicap to employment." Through his attorney, claimant requested review by the Director.

In August 1993, the Director issued an order finding that the insurer's ineligibility determination was "premature" because the "claim remains open, [claimant] is not medically stationary, and [claimant]'s permanent physical capacities are unknown." Therefore, the Director ordered the insurer to "redetermine [claimant]'s eligibility when his permanent physical capacities are known or he becomes medically stationary, whichever occurs first."

Claimant requested a hearing, asserting that his attorney was entitled to an assessed fee because, through his counsel's efforts, the insurer's notice of ineligibility was set aside. Alternatively, claimant sought an out-of-compensation fee. The Referee approved an out-of-compensation fee. However, finding that the insurer's notice was incorrect but not unreasonable, the Referee found no basis to award a carrier-paid fee under ORS 656.382(1) for claimant's counsel's efforts in setting aside the insurer's notice of ineligibility.

On review, claimant contends that he is also entitled to a carrier-paid attorney fee award under ORS 656.382(1). We agree. In reaching this conclusion, we rely on our recent decision in Gustavo Cantu-Rodriguez, 46 Van Natta 1801 (1994).

In Cantu-Rodriguez, we held that a carrier-paid attorney fee award under ORS 656.382(1) was available when a carrier unreasonably resisted the payment of compensation by issuing a premature notice of ineligibility for vocational services. We explained that an assessed attorney fee under ORS 656.382(1) was available when there was: (1) a compensable claim; and (2) unreasonable conduct; which (3) results in resistance to the payment of compensation. We found that the carrier's conduct in issuing the premature notice was unreasonable, and that such unreasonable conduct resulted in the resistance of the payment of compensation. Finally, we concluded that "compensation" under ORS 656.382(1) includes services for evaluating eligibility for vocational assistance. Therefore, based on this reasoning, we held that the claimant was entitled to an assessed attorney fee under ORS 656.382(1).

Applying that reasoning to this case, we first note that there is no dispute that claimant has a compensable claim. We also find that the insurer's conduct was unreasonable. The insurer concedes that its ineligibility notice issued "prematurely." The insurer asserts, however, that because it was complying with claimant's attorney's "demand" that it determine eligibility, its action was not unreasonable. We disagree. A request that a carrier determine a claimant's eligibility for vocational assistance cannot transform a premature ineligibility determination into reasonable conduct. Here, the record shows that claimant's permanent physical capacities were not yet ascertainable when the insurer issued its notice of ineligibility. Consequently, we conclude that the insurer had no basis for determining that claimant did not have "a substantial handicap to employment." As such, the insurer acted unreasonably in issuing its notice of ineligibility.

Furthermore, based on the reasoning in Cantu-Rodriguez, we find that such unreasonable conduct resulted in the resistance to compensation. Thus, we conclude that claimant is entitled to an assessed fee under ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we award $500 as a reasonable fee for claimant's counsel's services concerning the insurer's unreasonable resistance to the payment of compensation by means of its premature notice of ineligibility for vocational assistance. In reaching this conclusion, we have particularly considered 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. We have also taken into consideration that, as a result of the Referee's approval of an out-of-compensation fee for services in obtaining vocational rehabilitation benefits, claimant's counsel will also receive 25 percent of the increased temporary disability compensation that results from the Director's order. Finally, claimant is not entitled to an attorney fee for services related to securing his attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated April 22, 1994 is affirmed in part and reversed in part. That portion of the order that declined to award an assessed fee for obtaining a Director's order that set aside the insurer's notice of ineligibility for vocational assistance is reversed. For services concerning the insurer's unreasonable resistance to the payment of compensation, claimant's attorney is awarded an assessed 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
BARBARA J. BROWN, Claimant
WCB Case No. 93-03259
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Mongrain's order that: (1) awarded additional temporary disability; and (2) declined to award penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable injury on October 15, 1991. Claimant returned to work on November 8, 1991 and was laid off in January 1992.

A December 9, 1992 Notice of Closure awarded claimant temporary total disability (TTD) benefits from October 16, 1991 through November 7, 1991. (Ex. 20). The Notice of Closure was affirmed by an Order on Reconsideration. Claimant requested a hearing on the grounds that she was entitled to a further award of temporary disability.

The Referee found that claimant was performing modified work between November 8, 1991 and the date of her termination in January 1992 and awarded claimant temporary partial disability (TPD) benefits for that period. However, the Referee declined to award TPD after claimant was laid off in January 1992.

On review, claimant argues that she is substantively entitled to additional TPD benefits from the date of her lay off in January 1992 through September 14, 1992, contending that she proved that she was partially disabled through that date. The self-insured employer disagrees and contends that the Order on Reconsideration which affirmed the Notice of Closure should be affirmed.

A claimant's substantive entitlement to temporary disability accrues upon closure and is based on proof of disability due to the compensable claim during the time the claim was open. See SAIF v. Taylor, 126 Or App 658 (1994). Although medical verification of an inability to work is not necessary to be entitled to substantive temporary disability, such evidence may provide proof of disability. See id.

We agree with, and as supplemented below, adopt, the Referee's reasoning and conclusion that claimant was released to modified work on November 8, 1991 and was entitled to TPD from that date. However, we disagree with the Referee's conclusion that claimant was not entitled to further temporary partial disability after her January 1992 lay off.

This record supports the Referee's conclusions that claimant was temporarily partially disabled after she returned to work on November 8, 1991. Dr. Roberts' chart notes indicate that he restricted claimant's work activities when he released claimant to work. In this regard, on November 14, 1991, Dr. Roberts stated that claimant was "on kind of a light schedule right now and may continue to work." (Ex. 5-3). On November 27, 1991, Dr. Roberts stated that claimant "may continue to work five hours a day. Probably should avoid heavy lifting, should avoid using a phone without a headset." (Ex. 5-3). On December 30, 1991, Dr. Roberts stated that claimant could continue work avoiding heavy lifting and using the phone only with a headset. (Ex. 8). On January 30, 1992, after claimant was laid off, Dr. Roberts indicated that claimant would return for follow up in one month and expected claimant to be able to go back to work with minimal restriction at that time although she might have some ongoing problems with the neck and shoulder. (Ex. 12).

On May 20, 1993, Dr. Roberts indicated that he had no record of specific restrictions when he released claimant to work in the Fall of 1991. However, Dr. Roberts indicated that claimant was to avoid excessive and repetitive lifting with her left arm and to avoid holding her head at odd angles. (Ex. 22A; 23). Based on the record, including Dr. Roberts' contemporaneous chart notes, we conclude that Dr. Roberts' release was to modified work with limitations on lifting, repetitive use of her left arm, phone use and reduced hours. Thus, we agree with the Referee's conclusion that Dr. Roberts released claimant to modified work in November 1991.

However, we disagree with the Referee's conclusion that claimant was not entitled to further TPD benefits after her January 1992 lay off. In this regard, the record contains no evidence that Dr. Roberts released claimant to regular work after the lay off. To the contrary, Dr. Roberts' chart notes indicate that claimant continued to have disability related to the injury after January 1992. (Exs. 12; 13).

Accordingly, we conclude that claimant was temporarily and partially disabled after November 8, 1991. Although she was laid off in January 1992, the record indicates that claimant remained temporarily and partially disabled after her lay off. SAIF v. Taylor, supra. Under such circumstances, claimant is substantively entitled to temporary partial disability until September 14, 1992, her medically stationary date. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Claimant's temporary partial disability should be calculated by the employer based on claimant's proportionate loss of earning power at any kind of work. See OAR 436-60-030; Stone v. Whittier Wood Products, 124 Or App 117 (1993).

Penalties and Attorney Fees

We adopt the Referee's reasoning and conclusion concerning the penalty and attorney fee issue as set forth in his order.

ORDER

The Referee's order dated January 3, 1994 is modified in part and affirmed in part. The self-insured employer is directed to pay temporary partial disability benefits from November 8, 1991 to September 14, 1992. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ANA J. CALLES, Claimant
WCB Case No. 93-12389
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On November 9, 1994, we issued an Order on Reconsideration which: (1) republished our October 14, 1994 order that affirmed a Referee's order directing the SAIF Corporation to pay claimant's attorneys the fee portion of temporary disability compensation previously paid to claimant; and (2) awarded claimant a $600 insurer-paid attorney fee under ORS 656.382(2) for her counsel's services on Board review. SAIF has moved for reconsideration of our decision. Specifically, SAIF contends that: (1) our attorney fee award is inconsistent with a court ruling and case precedent; and (2) it would be inequitable to require SAIF to pay all of claimant's "out-of-compensation" attorney fee directly to claimant's counsel.

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 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
SHARON S. WEBSTER, Claimant
WCB Case No. 93-14155
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Bethlahmy's order that affirmed the November 17, 1993 Order of the Director suspending claimant's permanent total disability benefits. On review, the issue is the suspension of claimant's permanent total disability benefits. We reverse.

FINDINGS OF FACT

Claimant has a compensable claim with the SAIF Corporation dating from a December 1973 injury. She had been receiving permanent total disability (PTD) benefits since March 1985. On June 29, 1993, claimant was notified that SAIF had referred her for a "Disability Prevention Evaluation." (Ex. 6). She was scheduled for an appointment with Dr. Sturges and a two-day appointment with Progressive Rehabilitation Associates.

On July 8, 1993, claimant's attorney wrote to SAIF, confirming a telephone conversation with SAIF in which he had asked whether the scheduled appointment with Progressive Rehabilitation Associates was a compelled medical examination or a "Disability Prevention Evaluation." (Ex. 7). According to the letter, SAIF responded that it was a "Disability Prevention Evaluation." Claimant's attorney notified SAIF that claimant would not be attending the examination because it was not authorized by statute or administrative rule.

On the following day, SAIF sent claimant a "Notice of Appointment," notifying her of an appointment with Dr. Sturges and a two-day appointment at Progressive Rehabilitation Associates. The letter stated that "[t]he purpose of this examination is to obtain an additional opinion on your medical condition and treatment." (Ex. 8). The letter made no reference to a "Disability Prevention Evaluation."

On July 20, 1993, SAIF wrote to claimant's attorney concerning the scheduled examination. Relying on ORS 656.206(5), the letter stated: "Please be advised that SAIF has the statutory right to have your client examined in any fashion we deem necessary." (Ex. 9).

On July 21, 1993, claimant's attorney wrote to the Director, requesting resolution over the dispute about the appointment with Progressive Rehabilitation Associates. (Ex. 11). Claimant's position was that the appointment with Progressive Rehabilitation Associates included much more than the medical examination allowed by statute. Claimant also noted that the appointment did not qualify as a physical capacities evaluation.

Claimant subsequently attended the examination with Dr. Sturges, a psychiatrist. On July 23, 1993, Dr. Sturges diagnosed claimant with a "[m]ajor affective disorder, residual, moderately severe." (Ex. 12). He reported that claimant "remains permanently and totally disabled and that more aggressive treatment either by psychotherapy or medication would result in little benefit." (Id). Dr. Sturges concluded that claimant did not have the flexibility to engage in a work environment.

Claimant did not attend the appointments with Progressive Rehabilitation Associates on July 26 and 27, 1993. Thereafter, SAIF sought to suspend claimant's PTD benefits on the basis that claimant did not attend the "scheduled IME." (Exs. 13 & 14). On August 27, 1993, the Director denied SAIF's request to suspend claimant's PTD benefits because claimant's attorney had requested resolution of the dispute by the Director prior to the appointment date. (Ex. 17).

On September 17, 1993, the Director responded to claimant's attorney's request to resolve the dispute about the examination with Progressive Rehabilitation Associates. The Director stated that the insurer has the statutory authority to compel the worker to attend a vocational assessment or examination. (Ex. 18). The Director concluded that it would "be within the insurer's rights to pursue suspension of benefits if the worker failed to appear for the examination." (Id).

On September 28, 1993, SAIF notified claimant that she must attend an examination by Progressive Rehabilitation Associates on October 13 and 14, 1993. (Ex. 19). The letter stated that "[t]he purpose of this examination is to obtain an additional opinion on your medical condition and treatment." Claimant did not attend those scheduled examinations.

Thereafter, SAIF sought suspension of benefits on the ground that claimant had failed to appear at two "independent medical examinations" on July 26-27, 1993 and October 13-14, 1993. (Ex. 24). SAIF stated that it would be futile to reschedule another examination because claimant's attorney had advised her not to attend any independent medical examination.

On November 17, 1993, the Director suspended claimant's PTD benefits as of October 21, 1993. The Director stated that "[t]he insurer has statutory authority to compel the worker to attend a vocational assessment or examination." (Ex. 26). The Director concluded that claimant's reasons for not attending the October 13 and 14, 1993 examination at Progressive Rehabilitation Associates were invalid and therefore warranted suspension of compensation. Claimant requested a hearing challenging the Director's suspension order.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Director's suspension order, reasoning that the scheduled examination constituted a medical examination. The Referee concluded that the examination was not a disability prevention examination pursuant to OAR 436-10-015; rather, it was an examination pursuant to OAR 436-30-065, which requires the insurer to review each PTD claim every two years.

Claimant argues that her PTD benefits were improperly suspended. We agree based on the following reasoning.

We first clarify the issue before us. The issue is not whether SAIF has the statutory authority to compel claimant to attend a vocational assessment for purposes of reducing PTD benefits. Rather, the

issue before us is whether SAIF has the statutory and administrative authority to suspend claimant's PTD benefits under the facts in this case.[1]

The statute authorizing the suspension of PTD benefits is ORS 656.325(1)(a), which allows an insurer to suspend benefits if a worker refuses to submit to a medical examination. That statute makes no reference to a vocational assessment or examination. 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. However, no more than three examinations may be requested except after notification to and authorization by 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 the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268." (Emphasis added).

Consistent with the aforementioned statute, OAR 436-10-100(5)(a) (WCD Admin. Order 13-1992) provides that when a worker is required to attend an examination by a physician of the insurer's choice, the insurer shall "[c]omply with the notification requirements contained in OAR 436-60-095." Former OAR 436-60-095(1) (WCD Admin. Order 1-1992) provided that a "worker shall submit to medical examinations reasonably requested by the insurer or the director." The insurer must provide notice of

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[1] We note that the Director may have confused the two issues. The Order Suspending Compensation states, in part:

> "The worker contends that ORS 656.206 does not allow for examinations other than medical examinations, however, the Benefits Section of the Workers' Compensation Division informed the worker's legal representative on September 17, 1993, prior to the October 13 and 14, 1993 appointment, that 'The insurer has statutory authority to compel the worker to attend a vocational assessment or examination. The statute contemplates the need for critical information to determine whether a worker is capable of returning to work. A vocational assessment provides that kind of information.' Additionally, they stated, 'It would, therefore, be within the insurer's rights to pursue suspension of benefits if the worker failed to appear at the examination.'" (Ex. 26).

Even if we assume that the Director is correct that SAIF has the statutory authority to compel claimant to attend a vocational examination, it does not follow, under the present statutory scheme, that SAIF is therefore entitled to suspend claimant's benefits for the failure to attend a vocational examination.

The parties focus on ORS 656.206(5) and OAR 436-30-065, which provide that the insurer shall reexamine PTD claims every two years. ORS 656.206(5) provides, in part: "Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary or the director may require." Claimant argues that the legislative history demonstrates that the 1983 addition of the words "and other records" was never intended to expand the definition of "medical examination" to include vocational assessments. On the other hand, SAIF contends that it is not necessary to look to the legislative history because the legislature's intent is clear from the language and context of the statute.

We need not address that issue because, even if we assume that ORS 656.206(5) and OAR 436-30-065 allow an insurer to compel a vocational assessment in reexamining a PTD claim, neither ORS 656.206(5) nor OAR 436-30-065 grant an insurer the authority to suspend PTD benefits for the failure to attend a vocational assessment. The authority to suspend benefits is in ORS 656.325(1)(a), which permits an insurer to suspend benefits if a worker fails to attend a medical examination. We are not at liberty to "insert what has been omitted, or to omit what has been inserted" in construing a statutory provision. ORS 174.010.

Although SAIF may not obtain suspension of claimant's PTD benefits under the present circumstances, we note that a carrier may be allowed to suspend benefits if a worker "commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation." ORS 656.325(4); see also OAR 436-60-105(1) (WCD Admin. Order 94-055). As we mentioned earlier, a carrier may also attempt to reduce a claimant's PTD award by requesting a reevaluation of the award pursuant to ORS 656.206(5). Should a carrier choose such an action, we note that there is no prohibition preventing a carrier from submitting a vocational evaluation report based on a written record and a physician's description of a claimant's physical limitations. Likewise, in the event of a hearing request from a Director's "206(5)" order, a carrier could seek a referee's "pre-hearing" order compelling the claimant to appear at a vocational evaluation.

the appointment at least 10 days prior to the examination. Former OAR 436-60-095(2) provides that the notice of appointment shall contain, among other things, "(b) The purpose and kind of examination."[2]

On June 29, 1993, claimant was notified that SAIF had referred her for a "Disability Prevention Evaluation." (Ex. 6). An appointment was scheduled with Dr. Sturges and a two-day appointment was scheduled with Progressive Rehabilitation Associates. On July 8, 1993, when claimant's attorney asked whether the scheduled appointment with Progressive Rehabilitation Associates was a compelled medical examination or a "Disability Prevention Evaluation," SAIF responded that it was a "Disability Prevention Evaluation." (Ex. 7).[3]

On the day following claimant's attorney's inquiry about the "Disability Prevention Evaluation," SAIF sent claimant a "Notice of Appointment," notifying her of the same appointment. The letter stated that "[t]he purpose of this examination is to obtain an additional opinion on your medical condition and treatment." (Ex. 8). The letter made no reference to a "Disability Prevention Evaluation."

On September 28, 1993, SAIF notified claimant that she must attend a rescheduled examination with Progressive Rehabilitation Associates on October 13 and 14, 1993. (Ex. 19). The examination was scheduled from 8:45 a.m. to 3:30 p.m. on October 13 and from 9:30 a.m. to 4:00 p.m. on October 14, 1993. The letter stated that "[t]he purpose of this examination is to obtain an additional opinion on your medical condition and treatment." The "examining doctor" was listed as Progressive Rehabilitation Associates.

Although the September 28, 1993 notice of appointment provided claimant with information about the purpose of the examination, the notice has no information about the kind of examination to be performed. Therefore, it does not comply with former OAR 436-60-095(2)(b), which requires that the notice of appointment contain information about the "purpose and kind of examination." Furthermore, the reference to the "examining doctor" as Progressive Rehabilitation Associates does not provide any information about what doctor(s) will be examining claimant, the doctor's specialty or what type of activities claimant would be asked to perform during the examination. Such information would reasonably pertain to the "kind of examination," and it would be particularly insightful in a situation such as this where the examination was scheduled for two full days.

Moreover, even if we assume that SAIF's statement that "[t]he purpose of this examination is to obtain an additional opinion on your medical condition and treatment" adequately describes the purpose and kind of examination, the record does not establish whether claimant was scheduled to have a "medical examination" at Progressive Rehabilitation Associates.

At hearing, Mr. Lindley, a manager of Progressive Rehabilitation Associates, testified that the evaluation consists of a "medical evaluation performed usually by a physiatrist, a psychological testing and evaluation, a physical capacities evaluation that is performed by an occupational therapist, a conference and a report that follows." (Tr. 14). The psychological evaluation is normally provided by a psychologist and the occupational therapists are licensed and work in conjunction with a physician during evaluations. (Tr. 14-15).

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[2] Former OAR 436-60-095 (WCD Admin. Order 1-1992) was amended effective August 28, 1994 (WCD Admin. Order 94-055). We note that OAR 436-60-095(5)(b) now requires that the notice of appointment shall contain a "specific statement of the purpose for the examination and identification of the medical specialties of the examiners."

[3] "Disability prevention services" are defined in ORS 656.335(4) as "services provided to an injured worker to prevent the injury from causing continuing disability." ORS 656.335 applies when a worker has incurred a disabling compensable injury for which a determination order or notice of closure pursuant to ORS 656.268 has not been issued. Because claimant's claim has already been closed and she has been declared permanently totally disabled, it appears that any "disability prevention services" have no application in this case. Moreover, if the appointments with Progressive Rehabilitation Associates did consist of a "Disability Prevention Evaluation," such an evaluation did not authorize SAIF to suspend claimant's PTD benefits pursuant to ORS 656.325. OAR 436-10-105(5) provides that "[a]ny evaluation necessary to establish a disability prevention services program as defined in ORS 656.335 shall not be considered an insurer medical examination under ORS 656.325." (Emphasis added).

If the scheduled appointment was a "Disability Prevention Evaluation," the notice to claimant did not comply with OAR 436-10-105(6)(b), which provides that if an evaluation is scheduled by the insurer, the insurer must notify the worker of, among other things, "[t]he specific reasons for the evaluation, including an explanation of the type of services being considered."

However, Mr. Lindley was testifying generally about examinations conducted by Progressive Rehabilitation Associates. He stated that he did not know anything specifically about claimant's examination. (Tr. 15). When asked if vocational testing could be provided, Mr. Lindley replied: "They can be provided. They're not always provided. SAIF will request it if they choose to. Normally, SAIF has their own vocational providers or evaluators who do their vocational component." (Tr. 14). Mr. Lindley did not state whether or not SAIF had requested vocational testing for claimant.

We conclude that the record does not establish whether claimant was scheduled to have a "medical examination" at Progressive Rehabilitation Associates because there is no evidence in the record describing the details of claimant's scheduled examination. Furthermore, in light of the fact that claimant was initially notified that she was to have a "Disability Services Evaluation," it is unclear whether SAIF had requested that Progressive Rehabilitation Associates perform vocational testing.

In addition, even if we assume that claimant's scheduled examination was to consist of a medical evaluation performed by a physiatrist, psychological testing and evaluation and a physical capacities evaluation performed by an occupational therapist, SAIF has not explained why testing by an occupational therapist qualifies as a "medical examination" under ORS 656.325(1)(a). ORS 656.325(1)(a) does not define "medical examination" and SAIF does not point to a statutory or administrative definition that would include occupational therapy. Furthermore, OAR 436-10-100 (WCD Admin. Order 13-1992), which concerns the insurer's rights and duties, refers to medical examinations by physicians. OAR 436-10-100(1) provides that the insurer may obtain "three medical examinations of the worker by physicians of their choice * * *." See also OAR 436-10-100(5)(a) (the insurer shall comply with notification requirements "[w]hen a worker is required to attend an examination by a physician of the insurer's choice).

Former OAR 436-60-095(1) (WCD Admin. Order 1-1992) provides that a "worker shall submit to medical examinations reasonably requested by the insurer or the director." Similarly, former OAR 436-60-085(1)(a) (WCD Admin. Order 12-1992) provides, in part:

> "The Division will suspend compensation by order under conditions set forth in this rule. * * * The worker is not entitled to compensation during or for the period of suspension when:
>
> "(a) The worker refuses or fails to submit to, or otherwise obstructs, a medical examination reasonably requested by the insurer or the director. * * * The Division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination." (Emphasis added).

As previously noted, SAIF's September 28, 1993 "Notice of Appointment" to claimant did not comply with former OAR 436-60-095(2)(b) because it did not provide any information about the "kind of examination." The record also does not establish whether claimant was actually scheduled for a "medical examination." Under such circumstances, we conclude that the "medical examination" requested by SAIF was not "reasonably requested" pursuant to former OAR 436-60-095(1) (WCD Admin. Order 1-1992) and former OAR 436-60-085(1)(a) (WCD Admin. Order 12-1992). Moreover, the examination does not appear to be "reasonably requested" in light of Dr. Sturges' report that claimant "remains permanently and totally disabled and that more aggressive treatment either by psychotherapy or medication would result in little benefit" and his conclusion that claimant did not have the flexibility to engage in a work environment. (Ex. 12). See Cheryl A. Hampton, 46 Van Natta 920 (1994) ("special circumstances" and "reasonable cause" existed under OAR 436-60-085(1)(a) and OAR 436-60-095(4) for the claimant's failure to comply with conditions of the independent medical examination). Under these circumstances, we conclude that the Director did not have the statutory and administrative authority to suspend claimant's PTD benefits.

Consequently, we reverse the Director's suspension order and reinstate claimant's permanent total disability commencing with SAIF's termination of such benefits. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $6,000. ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated April 4, 1994 is reversed. The SAIF Corporation is directed to pay permanent total disability benefits beginning from the effective date of its termination of such benefits. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $6,000, payable directly to claimant's attorney.

In the Matter of the Compensation of
HELEN K. LARA, Claimant
WCB Case No. 93-12770
ORDER ON REVIEW
Charles J. Cheek, Claimant Attorney
Paul L. Roess, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Kekauoha's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

The insurer argues that claimant has failed to establish that her post-closure symptoms were more than a waxing and waning of symptoms of her accepted low back condition contemplated by a May 17, 1993 Determination Order that closed the claim. The only evidence that waxing and waning was contemplated before claim closure consists of an March 23, 1993 report by Dr. Malos, consulting neurosurgeon, who stated that claimant's "symptoms are probably going to wax and wane somewhat." (Ex. 8).[1]

Claimant argues that, under Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666 (1994), Dr. Malos' opinion may not be considered in analyzing the waxing and waning issue. We agree.

To establish a compensable aggravation, claimant must prove that her compensable condition has worsened since the law 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, rev den 312 Or 150 (1991). Finally, if claimant's prior permanent disability award contemplated future waxing and waning of symptoms of the compensable condition, claimant must proved that her worsening was more than the waxing and waning contemplated. ORS 656.273(8). If the permanent disability award did not contemplate waxing and waning of symptoms, ORS 656.273(8) does not apply. See Theodore W. Kinder, 46 Van Natta 391 (1994).

The issue presented by this case is whether, under ORS 656.273(8), a consulting physician's findings regarding waxing and waning may be considered in determining whether a permanent disability award contemplated waxing and waning of symptoms. For the following reasons, we answer that question, "no."

ORS 656.273(8) provides:

> "If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously been awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award."

In interpreting that statute, our task is to discern the legislature's intent. ORS 174.020. We first look to the text and context of ORS 656.273(8) to discern legislative intent. ORS 174.020; Porter v. Hill, 314 Or 86, 91 (1992). The context includes other statutes relating to the same subject matter. Porter v. Hill, supra, 314 Or at 91.

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[1] We refer to Dr. Malos as a consulting physician because the Referee found that Dr. Cummings was the attending physician. (Opinion and Order at 6). The parties do not challenge that finding.

The text of ORS 656.273(8) does not specifically address whether a consulting physician's pre-closure prediction of waxing and waning of symptoms will suffice to establish that waxing and waning was "contemplated by the previous permanent disability award." Therefore, we turn to the statutory context.

ORS 656.245(3)(b)(B) provides, in part:

> "Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for purpose of evaluating the worker's disability."

That statute prohibits the use of carrier-requested medical examinations to impeach the impairment findings of a claimant's attending physician. Koitzsch v. Liberty Northwest Ins. Corp., supra. We have applied the Koitzsch holding to prohibit the use of a physical therapist's testimony to impeach the impairment findings of a medical arbiter. Jerome D'Arcy, 46 Van Natta 416 (1994).

The upshot of ORS 656.245(3)(b)(B) is that only an attending physician's impairment findings may be considered in evaluating a worker's disability. No other medical experts' impairment findings may be considered, unless the attending physician ratifies those findings. See Roseburg Forest Products v. Owen, 129 Or App 442 (1994); Alex J. Como, 44 Van Natta 221 (1992). In view of these prohibitions, we conclude that, under ORS 656.273(8), only findings by, or ratified by, a worker's attending physician regarding waxing and waning of symptoms of a ratable condition may be considered in determining whether such waxing and waning was contemplated by the previous permanent disability award.

This conclusion is supported by the legislative history of ORS 656.245(3)(b)(B). In Koitzsch, the court concluded that the history of ORS 656.245(3)(b)(B) revealed the legislature's intent

> "to eliminate Board reliance on independent medical examinations as a basis for its evaluation of a worker's medical disability. The objective of the statute was the save employer's the cost of such examinations and to require the Board to consider only the attending physician's impairment findings in evaluating a disability." Koitzsch, supra, 125 Or App at 670.

That objective would be defeated if we interpreted ORS 656.273(8) as authorizing the consideration of any expert's impairment findings, because it would invite carriers to solicit pre-closure examinations regarding the waxing and waning of symptoms of ratable conditions in anticipation of future aggravation claims regarding those conditions. Accordingly, we interpret ORS 656.273(8) in accord with ORS 656.245(3)(b)(B), and conclude that only those findings by, or ratified by, an attending physician may be considering in determining whether a previous permanent disability award contemplated waxing and waning of symptoms of a ratable condition.

Applying this analysis to the instant case, we conclude that the Referee correctly declined to consider Dr. Malos' report in determining whether the Determination Order contemplated future waxing and waning of symptoms of claimant's low back condition. Dr. Malos was not the attending physician; moreover, Dr. Cummings, the attending physician, did not concur with Dr. Malos' anticipation of future waxing and waning of symptoms of claimant's accepted low back condition. Under the circumstances, ORS 656.273(8), as read in the context of ORS 656.245(3)(b)(B), precludes the consideration of Dr. Malos' report with respect to the waxing and waning issue. Because there is no other persuasive evidence that waxing and waning of symptoms was contemplated by the Determination Order, ORS 656.273(8) does not apply. Accordingly, we agree with the Referee that claimant need not establish that her worsening was more than a waxing and waning of symptoms contemplated by the prior award. See Theodore W. Kinder, supra.

The insurer argues that, under Libbett v. Roseburg Forest Products, 130 Or App 50 (1994), the Referee could consider Dr. Malos' report in determining whether the Determination Order contemplated future waxing and waning of symptoms of claimant's low back condition. We disagree. In Libbett, the Court of Appeals held that Koitzsch did not hold that the Board is required to accept an attending physician's opinion or that it may not consider other, non-medical evidence in evaluating the medical evidence or the claimant's disability. 130 Or App at 52. Neither of those issues is at stake here; accordingly, we find Libbett inapposite.

For the reasons stated in the Referee's order, as supplemented herein, we agree that claimant has established a compensable aggravation claim for a low back condition. Accordingly, we affirm the Referee's decision setting aside the denial of that condition.

Claimant is entitled to an 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 attorney fee for counsel'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 May 27, 1994 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
JOSLIN A. McINTOSH, Claimant
WCB Case No. 91-12955
ORDER ON REMAND
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. McIntosh v. The Other Woman, 130 Or App 211 (1994). The court has reversed our prior order, Joslin A. McIntosh, 45 Van Natta 1655 (1993), which: (1) declined to remand the claim to the Director for promulgation of a temporary rule regarding the Director's disability standards; and (2) declined to modify the approved attorney fee granted by the Order on Reconsideration. Citing Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

In September 1990, claimant suffered a compensable left leg injury. (Ex. 1A, 1B, 2). During surgery, three pins were inserted into the head of claimant's left femur. (Ex. 1B).

On March 20, 1991, claimant was examined by Dr. Woolpert, orthopedist, on behalf of the insurer. (Ex. 4A). He opined that claimant was not yet medically stationary. (Ex. 4A-4).

On June 4, 1991, Dr. Rabie examined claimant and opined that she was not yet medically stationary. (Ex. 6C-1) He recommended an independent medical examination to determine claimant's medically stationary status, her impairment, and her capability to return to work. Id.

On July 19, 1991, claimant was examined by Dr. Peterson, orthopedist, on behalf of the insurer. (Ex. 7). Dr. Peterson opined that claimant was medically stationary. (Ex. 7-5). He noted that claimant walked with a mild left-sided limp, bearing more weight on her right lower extremity. (Ex. 7-3). He also noted a well-healed four inch lateral thigh scar, mild visible left thigh atrophy, equal limb lengths at 37-1/2 inches, and mild hypesthesia over the anterior and lateral aspect of the left thigh. (Exs. 7-3, -4). He found mild scar tissue/fracture sensitivity. (Ex. 7-5).

Dr. Peterson also noted that "[m]uscle strength testing reveals giveway with resisted left hamstring testing and with resisted testing of the left hip flexors. Motor strength of the left lower extremity is otherwise within normal limits." (Ex. 7-4). Noting that claimant displayed moderate functional overlay, Dr. Peterson opined that no formal residual physical capacity restrictions were indicated. (Ex. 7-5).

Dr. Peterson measured claimant's ranges of motion of the right/left hips as follows: flexion 125/95 degrees, extension 15/10 degrees, internal rotation 25/0 degrees, external rotation 45/45 degrees, adduction 40/40 degrees, and abduction 55/55 degrees. (Ex. 7-4).

Dr. Rabie concurred with Dr. Peterson's report. (Ex. 8).

On September 3, 1991, a Determination Order awarded 6 percent (9 degrees) scheduled permanent disability for loss of use or function of claimant's left leg. (Ex. 9). The worksheet indicated that the award was based on decreased range of motion. (Ex. 9-2). Claimant requested reconsideration, disputing the rating of impairment, but not the findings used in rating her disability. (Ex. 10A).

On October 15, 1991, an Order on Reconsideration issued awarding an additional 7 percent (10.5 degrees) scheduled permanent disability for a total award of 13 percent (19.5 degrees). (Ex. 11). The permanent disability award was based solely on claimant's decreased range of motion. (Ex. 11-3). This amounted to an increase in compensation of $3,202.50. (Ex. 11-2). Claimant's counsel was allowed an attorney fee of $183.00, payable from the increased compensation awarded by the order. (Exs. 11-2).

On October 24, 1991, claimant supplemented a prior hearing request, appealing the Order on Reconsideration and raising additional issues of extent of scheduled permanent disability and attorney fees. At hearing, claimant sought remand to the Director for the adoption of temporary rules regarding her left leg/hip impairment (the bulk of which she contended was not addressed in the standards). The Referee eventually found that the Hearings Division was without authority to remand the claim to the Director. Consequently, the Referee affirmed the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

Relying on Gary D. Gallino, 44 Van Natta 2506 (1992), the Board declined to remand the claim to the Director for the adoption of a temporary rule pursuant to ORS 656.726(3)(f)(C). In addition, the Board affirmed the Referee's order and found that claimant was entitled to a total award of 13 percent scheduled permanent disability for her decreased range of motion, as awarded by the Reconsideration Order. Claimant appealed the Board's order. Citing Gallino v. Courtesy Pontiac-Buick-GMC, supra, the court reversed and remanded the case to the Board for reconsideration. We now proceed with our reconsideration.

Contending that the Director's disability rating standards do not address her impairment due to her left hip injury, claimant seeks remand to the Director for adoption of a temporary rule. Specifically, claimant contends a temporary rule is necessary to address the following impairments: (1) left femoral head shortening; (2) giveway weakness requiring the use of a cane; (3) thigh atrophy indicating a loss of strength; and (4) swelling and disabling pain in the surgical scar. We conclude that remand is not justified.

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." The Board has authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, supra. Claimant has the burden of proving that her disability is not addressed by the standards. See ORS 656.266; Susan D. Wells, 46 Van Natta 1127 (1994); Valorie L. Leslie, 46 Van Natta 1919 (1994).

Claimant became medically stationary after July 1, 1990, and she made a request for reconsideration pursuant to ORS 656.268. Therefore, in rating her permanent disability, we apply the disability rating standards in effect on the date of the September 3, 1991 Determination Order. OAR 438-10-010; 436-35-003(2). Those standards are provided in WCD Admin. Order 2-1991.

Claimant contends that she is entitled to additional scheduled permanent disability based on Dr. Woolpert's March 20, 1991 examination. However, Dr. Woolpert opined that claimant was not medically stationary at the time of that examination. Claimant was not determined to be medically stationary until July 19, 1991. Inasmuch as claimant was not medically stationary at the time of Dr. Woolpert's examination, the report is not persuasive evidence concerning the extent of claimant's permanent disability. See Jesus Mejia, 44 Van Natta 32 (1992). Accordingly, we do not rely on Dr. Woolpert's report.

For the same reason, we do not rely on the pre-medically stationary restrictions placed on claimant by other physicians (including Dr. Rabie). (Exs. 5A, 6, 6B-2, 6C).

The post-medically stationary medical evidence in the record concerning the extent of claimant's permanent disability comes from Dr. Peterson. (Ex. 7). Dr. Rabie concurred with Dr. Peterson's report.

(Ex. 8). Therefore, we rely on those findings in reaching our determination regarding the extent of claimant's permanent disability.

Claimant argues that she is entitled to additional scheduled permanent disability for impairment that allegedly is not addressed by the Director's disability rating standards. Therefore, claimant seeks remand to the Director for adoption of a temporary rule.

First, claimant contends that she has sustained a shortening of the left femoral neck, which necessarily resulted in an overall shortening of the left leg. Claimant argues that this impairment is not covered by the standards. We disagree with claimant's contentions for the following reasons.

We are not persuaded that claimant has a shortening of the left femoral neck. However, even assuming that claimant has a shortened femoral neck, such impairment is addressed by former OAR 436-35-230(2), which provides ratings for length discrepancies of an injured leg, whether the length change is due to an injury to the foot or to the upper leg. Consequently, remand under ORS 656.726(3)(f)(C) is not warranted.

In examining claimant's x-rays, Dr. Peterson noted that "[t]here is slight shortening of the femoral neck, but this may be rotational projection also." (Ex. 7-4). Nevertheless, Dr. Peterson found claimant's leg lengths were equal at 37-1/2 inches. (Ex. 7-3). Under such circumstances, we are not persuaded that claimant is entitled to a rating for length discrepancy of the injured leg.

Second, claimant contends that she is entitled to a rating for her left thigh atrophy, which she contends indicates a loss of strength. She also contends that she is entitled to a rating for "giveway weakness requiring the use of a cane." We consider both of these alleged impairments to be addressed by the following rules regarding loss of strength. Therefore, once again, remand is not warranted.

Former OAR 436-35-007(14) provides that impairment due to loss of strength is determined using a 0 to 5 grading system. Furthermore, a preponderance of the medical opinion is used to rate the loss and to identify the named spinal nerve root, peripheral nerve, or plexus which is responsible for the loss of strength. Id. Former OAR 436-35-230(8) and (9) specifically address loss of strength in the lower extremities. Former OAR 436-35-230(8) provides that loss of strength is rated when the cause is peripheral nerve injury, and it provides a table rating each nerve injury. Former OAR 436-35-230(9) provides that "[l]oss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired."

Here, Dr. Peterson did not rate any loss of strength or weakness in the left leg. Although he noted that claimant had a slight left thigh atrophy, he stated that "this mild degree is not associated with significant left lower extremity objective weakness." (Ex. 7-6). He also noted that giveway weakness was present over the left hip, but he opined that it was "more of a discomfort-anxiety giveway than true muscular weakness." (Ex. 7-6). Furthermore, Dr. Peterson gave no opinion that claimant had giveway weakness requiring the use of a cane. In fact, Dr. Peterson opined that no formal residual physical capacity restrictions were indicated. (Ex. 7-5). Finally, Dr. Rabie concurred with Dr. Peterson's report.

Although claimant testified that she needs to use a cane if she walks for extended periods of time, lay testimony is insufficient to establish "impairment" under the standards. Former 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). On this record, claimant has not established entitlement to a rating for loss of strength or weakness.

Third, claimant contends that she has swelling and disabling pain related to the surgical scar that is not rated by the standards. Dr. Peterson did not opine that claimant had disabling pain. However, he opined that claimant would continue to experience mild scar tissue/fracture sensitivity, especially with cold weather. (Ex. 7-5). He noted that this type of sensitivity was not to be confused with the type of pain and impairment associated with degenerative arthritis. Id. Furthermore, he found no evidence of any degenerative changes in claimant's left hip. Id.

The standards address pain. However, the standards allow an award for pain only to the extent that pain causes impairment that is measurable under the standards. Former OAR 436-35-010(2) and (3); Kelly D. Mustoe, 46 Van Natta 285 (1994), aff'd mem Mustoe v. Career Management Consultants, 130 Or App 679 (1994). Here, the record does not establish that claimant's pain causes measurable impairment. Although noting that claimant will have ongoing scar tissue/fracture sensitivity,

Dr. Peterson does not opine that claimant has any limitations or impairment due to that sensitivity. In fact, he stated that no physical capacity restrictions were indicated. (Ex. 7-5). This opinion was shared by Dr. Rabie.

In conclusion, we hold that claimant has failed to prove that the standards do not adequately address her disability. Consequently, remand to the Director is not warranted. See Susan D. Wells, supra (the Board had no authority to remand to the Director pursuant to ORS 656.726(f)(C) where the claimant did not prove that the standards did not adequately address her disability).

Regarding claimant's remaining contention relating to her impairment, she does not dispute the values assigned by the Order on Reconsideration for her loss of range of motion. However, she contends that she is entitled to a 5 percent award for a chronic condition limiting repetitive use of her leg. We disagree.

Former OAR 436-35-010(6) provides that 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[.]" 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); Kelly D. Mustoe, supra.

Claimant relies on the pre-medically stationary limitations provided by Dr. Rabie to support her claim for a chronic condition award. (Ex. 6C). However, as discussed earlier, because these limitations addressed claimant's condition before it became medically stationary, they are not persuasive evidence of claimant's permanent disability. Furthermore, although noting claimant's reported limitations, Dr. Peterson persuasively opined that claimant had no formal residual physical capacity restrictions. (Ex. 7-5). Dr. Rabie subsequently concurred with that opinion. (Ex. 8). Therefore, claimant is not entitled to an award for a chronic condition limiting repetitive use of the left leg. Accordingly, claimant is entitled to a total scheduled permanent disability award of 13 percent, as awarded by the Order on Reconsideration.

Attorney Fees

The October 15, 1991 Order on Reconsideration increased claimant's compensation by $3,202.50. (Ex. 11-2). The Director awarded an out-of-compensation fee of only $183.00, some $137.25 below the required 10 percent share provided under ORS 656.268(6)(a). The insurer paid the compensation and attorney fee as ordered by the Director. Claimant requested a hearing, contending that the insurer should pay the additional fee directly to her attorney.

Finding that the compensation awarded by the Order on Reconsideration had already been paid by the insurer, the Referee declined to award additional "out-of-compensation" fees to claimant's counsel. We find that claimant's counsel is entitled to an additional fee of $137.25 regarding the increased compensation awarded by the Order on Reconsideration. However, claimant's counsel must collect this attorney fee from claimant.

Pursuant to ORS 656.268(6)(a), the Director is required to award an out-of-compensation fee amounting to ten percent of the increased compensation. No discretion is allowed in determining the fee.

In cases where the insurer has paid compensation to a claimant that included an out-of-compensation fee that was owed to the claimant's attorney, the Board has developed two lines of reasoning in determining whether the claimant's attorney must recover the fee from the claimant or whether he or she may recover the fee from the insurer, with a offset allowed to the insurer against future permanent disability awards under the claim. Where the claimant's attorney has taken all reasonable precautions to secure the out-of-compensation fee, the Board has ordered the insurer to pay the fee to the attorney. Ana J. Calles, 46 Van Natta 2195 (1994); Nancy E. O'Neal, 45 Van Natta 1490, on recon 45 Van Natta 1591, on recon 45 Van Natta 2081 (1993). On the other hand, where the claimant's attorney failed to take preventive action to secure the out-of-compensation fee, the Board has found that the attorney must seek payment of the fee from the claimant. Gabriel M. Gonzales, 44 Van Natta 2399 (1992); Kenneth V. Hambrick, 43 Van Natta 1636 (1991); Gerald L. Billings, 43 Van Natta 399 (1991).

We find that the latter reasoning applies here. In making this determination, we find Hambrick, supra, analogous to the present case. In Hambrick, a referee's order granted increased compensation, but neglected to award an "out-of-compensation" fee from that increase. On review, we ultimately held that, although the claimant's counsel was entitled to an attorney fee, it would be inequitable to require

the carrier to pay the fee "as a result of the Referee's error and claimant's failure to timely request correction of that error." Hambrick, supra, at page 1637.

Here, claimant's attorney could have sought correction of the error by bringing it to the Department's attention before requesting a hearing. OAR 436-30-008(1). We note that, given the time frame in this case, claimant had several months after the Order on Reconsideration issued in which to request a hearing contesting that order.[1] Thus, claimant had ample time to seek Department correction of the error. Therefore, although claimant's attorney is entitled to the full $320.25 fee, it would be inequitable to require the insurer to pay the fee as a result of the Department's error and claimant's attorney's failure to take available preventive action and request Department correction of that error. Kenneth V. Hambrick, supra.

Consequently, claimant's attorney must seek payment of the remaining amount due ($137.25) from claimant rather than the insurer. Claimant's attorney may seek recovery of this fee in the manner outlined in Jane A. Volk, 46 Van Natta 681 (1994).

Accordingly, on reconsideration, the Referee's order dated October 7, 1992 is reversed in part and affirmed in part. That portion of the order that declined to award an "out-of-compensation" attorney fee is reversed. Claimant's attorney is awarded a $137.25 "out-of-compensation" fee. That fee shall be recoverable from claimant in the manner set forth in Jane A. Volk, supra. The remainder of the order is affirmed.

IT IS SO ORDERED.

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[1] If a claimant objects to a Determination Order, he or she must first request reconsideration of that order. ORS 656.268(5). If the claimant objects to the Order on Reconsideration, he or she may request a hearing under ORS 656.283 within 180 days after the Determination Order was mailed. ORS 656.268(6)(b). The time from the request for reconsideration until the reconsideration is made is not counted in this 180 day time limitation. Id.

Here, the Determination Order was mailed on September 3, 1991. (Ex. 9). Claimant requested reconsideration on September 30, 1991. (Ex. 10A). The reconsideration was made on October 15, 1991. (Ex. 11). On October 24, 1991, claimant supplemented a prior hearing request and appealed the Order on Reconsideration. Thus, at the time the Reconsideration Order issued, claimant had well over four months to request a hearing on that order.

Board Member Gunn specially concurring.

I am bound by the holding in Mustoe supra. However, I write to wish upon the court the pain and suffering the claimant will suffer for the rest of her life due to the compensable injury. Failure of the standards to address this disability and failure of the Board and Courts to make the Director and standards address this woman's disability means we all have failed to provide "substantial justice".

In the Matter of the Compensation of
KIMBERLY R. SOTO, Claimant
WCB Case No. 93-08936
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Nichols' order which upheld the self-insured employer's denial of her 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.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Tesar, the Referee found that claimant's carpal tunnel syndrome (CTS) was not compensably related to her October 1992 work incident. We disagree.

Claimant worked as a custodian. In October 1992, when she grabbed and pulled on a chair to slide across a room, claimant felt her right wrist "pop" with the immediate onset of pain in her wrist to the elbow. Claimant first sought treatment in March 1993 from her family doctor, who suspected a wrist strain. Claimant subsequently began treating with Dr. Warren, who diagnosed a ganglion cyst and right carpal tunnel syndrome. Dr. Warren opined that claimant's injury at work resulted in the formation of the ganglion cyst and resulted in swelling which caused the onset of symptoms of CTS.

Dr. Tesar performed a records review on October 28, 1993. He opined that claimant's CTS was unrelated to the October 1992 work incident and was idiopathic. Dr. Tesar explained that to have an acute CTS following an injury, the injury must involve significant crushing and tearing of tissues, most commonly seen after a fracture of a distal radius. Dr. Tesar concluded that claimant's incident was not the type of injury that would cause CTS because there was not a significant amount of trauma or soft tissue injury to cause severe swelling or later scarring.

Dr. Warren disagreed with Dr. Tesar's opinion. Dr. Warren explained that since claimant had enough of a wrist injury to result in the formation of a ganglion cyst, then she would also have sufficient swelling in the region of the carpus to develop CTS symptoms.

When medical experts disagree, we generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Warren's opinion.

Dr. Tesar did not examine claimant, but rather conducted a review of the file. Thus, Dr. Warren had a greater opportunity (through treatment and surgery) to observe claimant. In addition, Dr. Warren's opinion is more persuasive because it considers claimant's particular situation rather than relying on generalized expectations. Moreover, Dr. Warren persuasively rebutted the contrary conclusions of Dr. Tesar. Rather than altering his opinion, as found by the Referee, Dr. Warren further explained his opinion concerning the onset and progression of claimant's CTS.

Consequently, we rely on Dr. Warren's opinion. Based on Dr. Warren's opinion, we find that claimant's CTS is a condition that arose directly from the October 1992 work incident. Accordingly, claimant must establish that the work incident was a material contributing cause of her disability and need for treatment. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). After considering Dr. Warren's persuasive opinion, we find that claimant has met that requisite standard. Accordingly, the 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 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 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 February 28, 1994 is reversed in part and affirmed in part. That portion of the order which upheld the denial of the carpal tunnel syndrome is reversed. The denial of the carpal tunnel syndrome is set aside and the claim is remanded to the employer for processing. Claimant's attorney is awarded $3,000 for services at hearing and on Board review for prevailing over the employer's denial, to be paid by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
LARRY D. POOR, Claimant
WCB Case No. 93-05190
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Mills' order that: (1) excluded as rebuttal evidence a post-hearing report from claimant's physician; (2) upheld the self-insured employer's denial of claimant's occupational disease claim for hearing loss in his left ear; and (3) declined to award attorney fees for the employer's pre-hearing acceptance of his claim for hearing loss in his right ear. The employer moves to strike a portion of claimant's reply brief on the ground that it refers to evidence not in the record. On review, the issues are motion to strike, evidence, compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one change. In the fifth paragraph on page 2, we change the reference concerning the employer's acceptance of claimant's right ear claim from "Exhibit 10" to "Exhibit 15."

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer moves to strike a portion of claimant's reply brief on the ground that it refers to evidence not in the record. We do not consider any evidence not already contained in the record and, therefore, we will not consider those portions of claimant's reply brief that contain such a discussion.

Evidence

At hearing, the Referee held the record open to admit the post-hearing deposition of Dr. Hodgson. The employer had given notice that Dr. Hodgson would be called as an expert witness at the time of the hearing. Claimant did not object to allowing Dr. Hodgson's deposition to be taken post-hearing in lieu of his appearance at hearing. (O & O p.1). Claimant requested that the record be held open for rebuttal and the Referee reserved ruling on that request. (Tr.3).

After Dr. Hodgson's deposition was admitted and before the record closed, claimant submitted a report from Dr. Lipman as rebuttal evidence. The Referee sustained the employer's objection to the report. Relying on OAR 438-07-023, claimant argues that the Referee erred in refusing to reopen the record to admit the rebuttal evidence from Dr. Lipman.

The Referee found that, even if he were to consider Dr. Lipman's report, his conclusion would be the same. (O & O p. 3). We agree with the Referee that admission of Dr. Lipman's report will not affect the outcome of the case. Therefore, we decline to consider whether the Referee abused his discretion by not admitting the report.

Compensability

Claimant contends that we should afford greater weight to the opinion of his treating physician, Dr. Lipman. We ordinarily defer to the attending physician's opinion, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We do so because attending physicians generally have had a better opportunity to evaluate a claimant's condition than consulting physicians. Id. Here, however, the record indicates that Dr. Lipman saw claimant on one occasion. Given his limited opportunity to evaluate claimant's condition, we decline to give his opinion the greater weight ordinarily given to attending physicians' opinions.

After reviewing the record, we adopt the Referee's reasoning and conclusions regarding the compensability issue.

Attorney Fee for Claimant's Right Ear Claim

The insurer originally denied the claim for hearing loss in both ears. (Ex. 10). On the day before the hearing, the insurer accepted claimant's right ear hearing loss claim. (Ex. 15). Claimant contends on review that he is entitled to an attorney fee pursuant to ORS 656.386(1). The employer erroneously contends that claimant did not raise this issue at hearing. Claimant raised the issue of attorney fees at the beginning of the hearing and in the opening statement. (Tr. 1, 4).

Claimant's attorney filed a request for hearing and obtained medical reports that resulted in the rescission of the insurer's denial of claimant's right ear hearing loss claim. In light of such circumstances, we find that claimant's counsel was instrumental in obtaining compensation for claimant's right ear claim without a hearing and is entitled to an attorney fee under ORS 656.386(1). See Sentrol, Inc. v. Bronson, 112 Or App 354 (1992); Jones v. OSCI, 108 Or App 230, 232 (1991).

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's efforts in obtaining the acceptance of claimant's right ear hearing loss claim without a hearing 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 the record), the value of the interests involved, the complexity of the issue, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for services related to securing his attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

Finally, the Referee's order erroneously upheld the employer's March 9, 1993 denial in its entirety. The employer had originally denied the claim on the basis that claimant's work exposure was not the major contributing cause of his hearing loss. (Ex. 10). On the day before the hearing, the employer accepted claimant's right ear hearing loss claim. We correct the "order" portion of the Referee's order to provide that the employer's March 9, 1993 denial is set aside to the extent it denies claimant's right ear hearing loss claim. That portion of the claim is remanded to the employer for processing in accordance with law. The remainder of the employer's denial is upheld.

ORDER

The Referee's order dated March 16, 1994 is affirmed in part and reversed in part. That portion of the Referee's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1) is reversed. For claimant's counsel's pre-hearing services which were instrumental in obtaining compensation for claimant's right ear hearing loss, claimant's attorney is awarded $750, payable by the self-insured employer. The employer's March 9, 1993 denial is set aside insofar as it pertains to claimant's right ear hearing loss claim and the claim is remanded to the employer for processing according to law. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ZORA A. RANSOM, Claimant
WCB Case No. 93-09262
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Thye's order that declined claimant's request to appoint a medical arbiter or an independent medical examination to rate the extent of permanent disability. On review, claimant contends that because an Order on Reconsideration improperly issued without the appointment of a medical arbiter, the Referee should have appointed a medical arbiter or examiner to rate her permanent disability.

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

The relevant facts are as follows. Claimant's claim was closed by a December 16, 1992 Determination Order, which did not award permanent disability. On March 5, 1993, the insurer requested reconsideration of the Determination Order. The insurer indicated that it disagreed with the medically stationary date. The Department and claimant's attorney received the insurer's request for reconsideration on March 8, 1993.

On March 8, 1993, the Department sent claimant a reconsideration acknowledgment letter advising claimant, inter alia, that any additional information to be considered must be submitted to the Appellate Review Unit within six working days. Claimant's attorney was not copied, but he did receive the acknowledgment letter on March 22, 1993.[1]

On March 31, 1993, the Department issued its Order on Reconsideration, finding an earlier medically stationary date. On April 8, 1993, claimant requested reconsideration of the Determination Order and raised all issues concerning that order, including impairment findings used in rating disability. On April 28, 1993, the Department denied claimant's request for reconsideration for lack of jurisdiction. Specifically, the Department found that the reconsideration process had been completed and that claimant failed to timely respond to the insurer's request for reconsideration.

Claimant contends that she was not required to file a cross-request for reconsideration in response to the insurer's reconsideration request and that her subsequent request for reconsideration was timely. Claimant further asserts that because her reconsideration request was timely, she is entitled, under ORS 656.268(7), to a medical arbiter examination. For the reasons discussed below, we disagree.

If the claimant or the insurer objects to a determination order, the objecting party must first request reconsideration of the order. ORS 656.268(5). If the basis for the objection to a determination order is disagreement with the impairment findings used in rating of the claimant's disability, the Director shall refer the claim to a medical arbiter. ORS 656.268(7). Thus, it is the objecting party which frames the issues before the Department and thereby determines whether appointment of a medical arbiter pursuant to ORS 656.268(7) is required. Randy M. Mitchell, 44 Van Natta 2304, 2305 (1992).

The reconsideration process is initiated upon the Department's receipt of a written request for reconsideration. ORS 656.268(6)(a) requires that the reconsideration process be completed within 18 working days from the date of the Department's receipt of the request for reconsideration. In Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991), the court determined that the reconsideration process before the Department was to be completed within the statutory time limit. The intent of the time constraint was to speed the process of claim resolution. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

[1] We find that the Department's failure to copy claimant's attorney did not excuse claimant from timely responding to the insurer's request for reconsideration. The reconsideration request, which claimant's attorney had received, notified claimant of the six day time period for submitting information. In addition, when claimant's attorney received the insurer's reconsideration request on march 22, 1993, he could have contacted the Department to ascertain the deadline for submitting information. Not only did claimant's attorney not make such a contact, but it was not until some 17 days later that claimant's attorney requested reconsideration.

In response to Benzinger, the Department amended OAR 436-30-050 to impose a six-working-day time limit for the correction of erroneous information and the submission of evidence. See OAR 436-30-050(7) and (8). Relevant to this case in particular, OAR 436-30-050(7)(d) provides that "[t]he parties may not request an arbiter examination *** after the sixth working day from receipt of the reconsideration request."

To further the policy of an expeditious reconsideration process, we have interpreted OAR 436-30-050(7)(d) to require that an arbiter request be received by the Department within six working days following receipt of the reconsideration request. Jodi Oatney, 46 Van Natta 1759, 1760 (1994)(Department not required to refer claim to medical arbiter where the Department did not timely receive the claimant's amended reconsideration request). That policy would be disregarded if, as claimant contends, more than one request for reconsideration is allowed. Rather, in accord with the statute and rules, all issues and evidence related to the claim should be submitted and decided within a single reconsideration process, since the receipt of the reconsideration request triggers the six-day limitations. See Jodi Oatney, supra; ORS 656.268; OAR 436-30-050(7).

Here, the Department completed its reconsideration proceeding on March 31, 1993. Claimant submitted her April 8,1993 request for reconsideration after the reconsideration process had been completed. In addition, the request was submitted more than six working days after the Department's March 8, 1993 receipt of the insurer's request for reconsideration. OAR 436-30-050(7)(a). Accordingly, claimant's reconsideration request is untimely.

Because the objecting party to a determination order determines whether appointment of a medical arbiter is required and because claimant failed to timely raise this issue, she is precluded from seeking appointment of a medical arbiter pursuant to ORS 656.268(7). See OAR 436-30-050(7)(d); Jodi Oatney, supra.

Neither the statutes nor the administrative rules preclude claimant from raising an issue at hearing that was not raised before DIF on reconsideration. See Leslie v. U.S. Bancorp, 129 Or App 1 (1994). Thus, claimant may contest the impairment findings rendered during the reconsideration proceeding. Nevertheless, in doing so, the medical evidence that can be considered is limited. There are statutory restrictions on who may make findings regarding the worker's impairment for purposes of evaluating disability and also on when that information may be made and considered. See e.g., ORS 656.245(3)(b)(B); 656.268(7); 656.283(7). ORS 656.268(7) and OAR 436-30-050(7)(c) authorize the Director, as part of the reconsideration process, to refer the claim to a medical arbiter. ORS 656.268(6)(a) further provides that the reconsideration process may be extended when a medical arbiter review has been scheduled. Thus, the statute specifically limits appointment of a medical arbiter by the Director. Claimant failed to timely request appointment of a medical arbiter during the reconsideration process. Accordingly, we agree with the Referee's conclusion concerning the refusal to allow a medical examination.[2]

ORDER

The Referee's order dated March 16, 1994, as supplemented on March 23, 1994, is affirmed.

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[2] Claimant sought the appointment of a medical arbiter/examiner to cure the failure of proof on the extent of disability issue. However, there was an alternative cure available. Because no medical arbiter was appointed, claimant was permitted to offer subsequent medical evidence of her impairment. See Scheller v. Holly House, 125 or App 454 (1993). Such evidence would be limited to medical opinions, either rendered or ratified by her attending physician, concerning the extent of her disability at the time of reconsideration. See ORS 656.245(3)(b)(B), 656.283(7). Because she did not elect this cure, there is no medical evidence of impairment in this record.

In the Matter of the Compensation of
BEVERLY M. BROWN, Claimant
WCB Case No. 93-07620
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Davis' order that set aside its denial of claimant's occupational disease claim for a right upper extremity condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded, inter alia, that the reports of Dr. Lee, as concurred with by Dr. Mandiberg, established that claimant's right upper extremity condition was compensably related to her work exposure at the employer. Because we conclude that there has been a failure of proof, we disagree.

Claimant initially sought treatment for right upper extremity complaints in August 1991. (Exs. 1-4). Claimant sought treatment twice in 1992 for right arm complaints. (Exs. 3, 4). On March 9, 1993, claimant began treating with Dr. Mandiberg, who tentatively diagnosed tendinitis. (Ex. 6; see Ex. 8).

On April 9, 1993, Dr. Neufeld examined claimant on the insurer's behalf. (Ex. 13). Neufeld concluded that claimant had right arm pain without objective orthopedic or neurologic findings. (Id. at 6). He was unable to relate her complaints to her work activities. (Id.) Dr. Mandiberg concurred in Dr. Neufeld's report. (Exs. 15, 17).

On May 20, 1993, claimant began treating with Dr. Layman. (Ex. 19). Dr. Layman diagnosed right upper extremity myofascial problems. (Ex. 20-2). Layman obtained a bone scan and a nerve conduction study, which were normal. (Id.) He did not render an opinion regarding causation. (See Exs. 20, 22).

Claimant began treating with Dr. Lee on August 9, 1993. (Ex. 25). Lee had performed claimant's earlier nerve conduction study. (Ex. 20-2). Dr. Lee diagnosed right forearm myofascial pain and shoulder/neck strain. (Ex. 25).

In a "check-the-box" letter authored by claimant's counsel, Dr. Lee answered "yes" to the question, "In your opinion, were [claimant's] work activities and exposures at [the employer] over the preceding three years the major contributing cause of her right upper extremity complaints/myofascial pain problems?" (Ex. 27). He also answered "yes" to the question, "In your opinion, were [claimant's] work activities and exposures the major contributing cause of her need for medical care and treatment she has sought and received this year for her right upper extremity/myofascial pain problems?" (Id.) Dr. Lee did not explain his answers. (See id.)

Thereafter, Dr. Mandiberg signed a "check-the-box" letter authored by claimant's counsel, answering in the affirmative the same questions posed in the "check-the-box" letter to Dr. Lee. (Ex. 25A).

Claimant relies on the final reports of Drs. Lee and Mandiberg as evidence of the compensability of her right upper extremity condition as an occupational disease. We find those reports insufficient to meet her burden of proof.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physicians, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Conversely, we give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports. Marta I. Gomez, 46 Van Natta 1654 (1994).

We find persuasive reasons not to rely on Drs. Lee's or Mandiberg's final reports. Although Dr. Lee became claimant's "treating physician" in August 1993, he only saw her twice. Consequently, we are not inclined to afford him any preference as an attending physician. More importantly, Dr. Lee's causation opinion is an unexplained, conclusory "check-the-box" report that lacks any persuasive foundation. Marta I. Gomez, supra. For these reasons, we discount Dr. Lee's reports.

We conclude likewise regarding Dr. Mandiberg's reports. Although Dr. Mandiberg treated claimant for several months, he initially agreed with Dr. Neufeld that claimant's right upper extremity condition was not work-related. Then, without explanation, he changed his opinion. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Moreover, that changed opinion consisted of the very same type of unexplained "check-the-box" report as that issued by Dr. Lee. See Marta I. Gomez, supra. For these reasons, we afford Dr. Mandiberg's causation opinion no probative weight.

In sum, we conclude that claimant has failed to establish that her right upper extremity condition is compensably related to her work activities. Accordingly, we reverse the Referee's decision setting aside the insurer's denial of that condition.

ORDER

The Referee's order dated June 9, 1994 is reversed. The insurer's denial is reinstated and upheld in its entirety. The Referee's attorney fee award is reversed.

December 14, 1994 Cite as 46 Van Natta 2456 (1994)

In the Matter of the Compensation of
MARTHA M. HANSEN, Claimant
WCB Case No. 94-00087
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Peterson's order that affirmed an Order on Reconsideration that awarded 22 percent (33 degrees) scheduled permanent disability bilaterally for loss of use or function of the left and right forearms. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the Referee's order with the following clarification of the calculation of claimant's scheduled permanent disability.

When converting digit impairments to hand impairment, each digit is rated and converted to values for loss in the hand, then the converted values are added to determine the total hand impairment. OAR 436-35-070(2), WCD Admin Order No. 6-1992.

Claimant has the following compensable sensory loss in her digits: 8 percent loss in the thumbs bilaterally; 8 percent loss in the index fingers bilaterally; 8 percent loss in the middle fingers bilaterally; and 9 percent loss in the ring fingers bilaterally. OAR 436-35-110(1).

We agree with the Referee's analysis of the medical evidence and his conclusion that the medical evidence establishes only a bilateral loss of strength in the thumb abductors & opponens due to median nerve damage, not a loss of grip strength in her hands. Due to median nerve involvement, muscle strength of the thumb abductors and opponens is 2/5 bilaterally. (Exs. 26-2, -3). This translates to 33 percent loss of use or function of the thumbs bilaterally. OAR 436-35-007(14), 436-35-110(8).

The impairment values to the thumbs are combined to obtain a total impairment of 38 percent of the thumbs bilaterally. OAR 436-35-005(4). This value is converted to an impairment of the hand of 13 percent bilaterally. OAR 436-35-070(3). The bilateral impairments to the index fingers, middle fingers, and ring fingers are converted to impairment of the hand of 2 percent, 2 percent, and 1 percent respectively. OAR 436-35-070(4), (5), (6). The converted hand values are added for a total of 18 percent (13 + 2 + 2+ 1). OAR 436-35-070(2).

Claimant is entitled to 5 percent chronic condition impairment when a preponderance of the medical evidence establishes that she is unable to repetitively use a "body part" due to a chronic and permanent medical condition. OAR 436-35-010(6). "Body part" includes the "hand/wrist." OAR 436-35-010(6)(a). Here, the parties do not dispute the fact that, as a result of her chronic compensable bilateral carpal tunnel syndrome condition, claimant is unable to repetitively use her wrists. Therefore, claimant is entitled to 5 percent chronic condition impairment bilaterally to her wrists (forearms).

When two or more parts of the same body part are impaired, each is rated separately and each rating is converted to a value for the impaired part which is closest to the body which, in this case, is the forearm. OAR 436-35-120(4); Larry E. Kadrmas, 43 Van Natta 1926 (1991). These converted values are then combined (not added). Id.

The standards provide no values for converting a loss in the hand to a loss in the forearm. Instead, impairments in the hand and forearm are valued equally by both statute and standards. Larry E. Kadrmas, supra; see ORS 656.214(2)(b) (loss of one forearm at or above the wrist joint, or the loss of one hand, is rated at 150 degrees, or a proportion thereof for less than a complete loss); OAR 436-35-090 (provides a table for converting a loss in the "hand/forearm" to a loss in the "arm"). Accordingly, claimant's hand impairment (18 percent) is combined with her wrist (forearm) impairment (5 percent) for a total forearm (wrist) impairment of 22 percent (33 degrees) bilaterally. OAR 436-35-120(4).

ORDER

The Referee's order dated April 15, 1994 is affirmed.

December 14, 1994 Cite as 46 Van Natta 2457 (1994)

In the Matter of the Compensation of
FRED W. MILLER, Claimant
Own Motion No. 94-0253M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our September 29, 1994 Own Motion Order of Dismissal that dismissed claimant's request for own motion relief. On October 14, 1994, we abated our order for reconsideration. The SAIF Corporation was granted 14 days within which to respond. Inasmuch as that 14-day period has expired and no such response has been forthcoming, we proceed with our reconsideration.

We begin with a review of the facts. SAIF initially submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on January 7, 1990. Claimant requested temporary disability compensation for his current L5-S1 disc and joint instability condition.

SAIF denied the compensability of claimant's current condition, and claimant requested a hearing. (WCB Case No. 94-07192). The Board consolidated the own motion matter with the hearing pending resolution of that litigation.

On September 15, 1994, the hearing convened in Portland, Oregon. Claimant was represented through his attorney and the parties entered into a stipulation on the record. On September 20, 1994, Referee Mills issued a "Stipulated Order," which recorded the parties' stipulation and resolved the parties' dispute pending before the Hearings Division. Under the order, claimant stipulated to withdrawal of his request for own motion relief. Additionally, claimant withdrew his request for hearing regarding "all other issues raised or raiseable."

By letter dated October 11, 1994, claimant's attorney requested that Referee Mills abate the September 20, 1994 Stipulated Order and reinstate claimant's requests for hearing and for own motion relief. That same date, claimant's attorney withdrew as claimant's counsel in all Workers' Compensation matters. By letter dated November 2, 1994, Referee Mills denied claimant's request to abate the September 20, 1994 Stipulated Order.. Neither party requested Board review of the Stipulated Order.

The terms of the parties' stipulation are binding. See Evans v. Rookard, Inc., 85 Or App 213, 214 (1987); Richard A. Colclasure, 46 Van Natta 1246, 1251 (1994); 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 a 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 appropriate route to challenge a stipulation is a request for Board review. Dennis Entriken, 46 Van Natta 1439 (1994). A referee's order approving a stipulation results in dismissal of a hearing request and is a final, appealable order. Glen D. Roles, 42 Van Natta 68, 72 (1990) (order dismissing hearing request is final, appealable order notwithstanding the fact the order did not set forth parties' appeal rights). The Stipulated Order in this case memorialized the claimant's withdrawal of both his request for hearing regarding all issues "raised or raiseable at this time," and his request for own motion relief. Pursuant to that order, nothing remains to be done.

The Referee denied claimant's request to abate the Stipulated Order. Therefore, the order was final under ORS 656.295(3) unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requested Board review under ORS 656.295. ORS 656.289(3). Here, although claimant requested the Referee to abate the Stipulated Order, he did not request Board review of that order. Neither party requested review of the order within 30 days. Thus, we conclude that the September 20, 1994 Stipulated Order was final.

The September 1994 stipulation was approved by a referee and, therefore, binds claimant to its terms. Fimbres v. Gibbons Supply Co., supra; International Paper Co. v. Pearson, supra. Under those terms, claimant withdrew his request for own motion relief regarding his current low back condition. Based on that withdrawal, claimant's own motion claim was properly dismissed.

Accordingly, our September 29, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 29, 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
JUDY A. JACOBSON, Claimant
WCB Case No. 93-03093
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of that portion of Referee McCullough's order that set aside its denial of claimant's aggravation claim for a low back injury. On review, the issue is aggravation.

We adopt and affirm the Referee's order except for the second to last paragraph on page 3 and the discussion regarding whether claimant's worsening was more than the waxing and waning contemplated by the prior permanent disability award. We provide the following supplementation.

In May 1990, claimant sustained a compensable back injury. A March 1991 Determination Order awarded 27 percent unscheduled permanent disability. After an Order on Reconsideration and a hearing, claimant ultimately was awarded 25 percent unscheduled permanent disability by a Board order. In December 1992, claimant experienced worsened symptoms. The Referee found that claimant proved a compensable aggravation.

In establishing a compensable aggravation of a condition for which the worker has been previously awarded permanent disability, the worker must show that the worsening is greater than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8). With regard to this requirement, the Referee determined that the March 1991 Determination Order contemplated "future symptom flare-ups" and that claimant's worsening was greater than such prediction.

We disagree that the previous permanent disability award contemplated waxing and waning of claimant's compensable low back injury. Neither the Determination Order, Order on Reconsideration, Referee's order, nor Board's order contain any prediction or anticipation of a waxing and waning. The Referee relied upon medical evidence from the treating physician rendered shortly before the issuance of the Determination Order restricting claimant from repetitive bending, twisting, heavy lifting, and stooping. (Ex. 11).

A finding that the previous permanent disability award contemplated waxing and waning can be based on medical evidence existing at the time of the award predicting such flare-ups. E.g., Lucas v. Clark, 106 Or App 687, 691 (1991). Here, we find that the restrictions imposed on claimant related to her impairment rather than constituting a prediction that claimant's symptoms would flare if she engaged in activity beyond her restrictions. In other words, we find that claimant's restrictions provided evidence of her ability to perform or not perform certain activity without necessarily showing that claimant's symptoms would fluctuate. Therefore, in the absence of evidence predicting symptomatic flare-ups, we conclude that claimant was not required to satisfy ORS 656.273(8). With regard to the remaining elements, we agree with the Referee's analysis and adopt that portion of his order.

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

ORDER

The Referee's order dated January 10, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
JUDY A. JACOBSON, Claimant
WCB Case No. 93-03093
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Bostwick, et al., Defense Attorneys

The insurer requests reconsideration of our November 3, 1994 Order on Review that affirmed the Referee's order setting aside the insurer's denial of claimant's aggravation claim. Our order adopted the Referee's order except for the discussion finding that claimant's worsening was more than the waxing and waning contemplated by the prior permanent disability award and provided a supplementation finding instead that ORS 656.273(8) was not applicable.

With regard to the discussion concerning ORS 656.273(8), the insurer asserts that the "Board has made findings not urged by claimant, and obviously not briefed by the parties." We first note that, given our de novo review, we may consider any issue addressed by the Referee. See, e.g., Destael v. Nicolai Co., 80 Or App 596, 600 (1986). Furthermore, although claimant did not challenge the Referee's application of ORS 656.273(8), the insurer asserted on review that the Referee erred in determining that claimant had satisfied the statute. Under these circumstances, we find no impropriety with our discussion concerning ORS 656.273(8).

Furthermore, the insurer contends that neither the Board nor the Referee "dealt with our alternative argument that any worsening was the result of a non-compensable condition." We disagree. Our order adopted that portion of the Referee's order finding that claimant's compensable chronic low back strain was the major contributing cause of her worsened condition. Having adopted that finding, we also necessarily decided that the worsening was not in major part due to a noncompensable condition.

Finally, the insurer objects to the assessed fee of $1,000 awarded to claimant's attorney on review. According to the insurer, claimant's brief on review "did not even address the issue felt important by the Board" and, therefore, was "pointless."

Because the insurer requested review of the Referee's order and the Board did not disallow or reduce the compensation awarded to claimant, claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). In determining an appropriate amount, the Board considers the factors contained in OAR 438-15-010(4). That rule does not require that claimant's brief on review mirror the Board's findings contained in its order. Furthermore, based on the factors in the rule, as discussed by our order, we continue to conclude that $1,000 is a reasonable assessed attorney fee in this case.

We withdraw our November 3, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our November 3, 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
RICHARD P. BECKEL, Claimant
WCB Case No. 93-15223
ORDER ON RECONSIDERATION
Skalak & Alvey, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Claimant requests reconsideration of our November 16, 1994 Order on Review that affirmed Referee Garaventa's order that: (1) upheld the SAIF Corporation's denial of claimant's spinal stenosis; and (2) declined to assess a penalty for an allegedly unreasonable denial. Specifically, claimant contends that there is no support for our conclusion that "the persuasive medical evidence establishes that claimant's preexisting spinal stenosis, in combination with his August 25, 1993 work injury, resulted in the L4-5 disc herniation, which SAIF has already accepted." (Order on Review at 2; emphasis in original). Rather, claimant argues, the resultant condition in this case is the herniated disc combined with the spinal stenosis, which is compensable under ORS 656.005(7)(a)(B).

We withdraw our November 16, 1994 order for reconsideration. After further consideration, we continue to conclude that claimant has failed to establish that his spinal stenosis is compensable under ORS 656.005(7)(a)(B).

Claimant refers us to a report by Dr. Waldram, treating surgeon, which states:

> "The major contributing cause of [claimant's] need for treatment was his herniated disc in all all [sic] probability caused by the accident combined with the pre-existing foraminal stenosis necessitating surgical treatment." (Ex. 30).

Claimant argues that Dr. Waldram's opinion means that his disc herniation and spinal stenosis combined to create the need for surgery. We disagree.

We read Dr. Waldram's report as stating: (1) the need for treatment was claimant's herniated disc; and (2) the disc condition probably was caused by his accident in combination with the preexisting spinal stenosis. It follows that the spinal stenosis did not result from the accident; rather, it combined with the accident to produce the disc herniation. That claimant also required surgery to treat his spinal stenosis does not alter our conclusion.

Claimant's argument ignores Dr. Waldram's statement that claimant's spinal stenosis was preexisting. That necessarily means the stenotic condition did not result from either the accident or the ensuing disc herniation. For these reasons, we reject claimant's arguments on reconsideration.

Accordingly, we withdraw our prior order. On reconsideration, as supplemented herein, we republish our November 16, 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
NICOLE M. DOBOS, Claimant
WCB Case No. 93-14303
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for a right upper back and shoulder condition. On review, the issue is compensability.

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

In March 1993, claimant had a motor vehicle accident (MVA) and was treated for cervical, thoracic and lumbar spine symptoms. In May 1993, claimant was released for her regular work as a housekeeper. On August 30, claimant sought treatment from Dr. Snow, osteopath, for right-sided cervical and trapezius pain. Based on Dr. Snow's opinion, the Referee found that claimant's right upper back and shoulder condition was compensable. The insurer asserts that Dr. Snow's opinion is not persuasive because it relies on an inaccurate history.

The record contains two opinions regarding causation. Examining physicians Dr. Marble, orthopedic surgeon, and Dr. Reimer, neurologist, diagnosed a history of "diffuse musculoskeletal pain complaints without obvious organic pathology" following the March 1993 MVA and a history of "sudden increase in use pattern while working in late July and early August 1993, which was associated with the onset of complaints of pain in the neck, upper back, right upper extremity, and right lower extremity." (Ex. 16A-5). The panel also found that "the working activities are the reason [claimant] returned to treatment" and that her symptoms "consisted of a simple overuse type of problem related from a sudden change in the type of work she did." (Id. at 6).

In a report to claimant's attorney, Dr. Snow related a history that, following the March 1993 MVA, claimant "sustained injuries involving the upper left cervical, thoracic and shoulder areas" with subsequent improvement and release to regular work. (Ex. 17-1). Dr. Snow further noted that, on August 30, 1993, claimant sought treatment for "increased right shoulder and right sided upper back discomfort," which was in "marked contrast to her previous complaints from the motor vehicle accident always involving the left side of her mid back and neck." (Id). According to Dr. Snow, it was "important to separate the injuries suffered in her March 1993 car accident from the injuries experienced secondary to her work in late August in that they involved different musculoskeletal distributions," finding that the work was the "major contributing cause for her right shoulder, thoracic and leg complaints." (Id. at 2).

During his deposition, however, Dr. Snow acknowledged that claimant exhibited diffuse bilateral pain following the MVA, explaining that such symptoms were typical of injuries from car accidents. (Ex. 18-16). Dr. Snow further explained that the severity of claimant's right-sided symptoms were significantly less than those exhibited on August 30; in particular, Dr. Snow found no evidence that claimant exhibited spasms after the MVA. (Id. at 24-25). Dr. Snow also noted that claimant had progressively improved following the MVA, eventually being released to regular work and working full-time four to six weeks before his examination on August 30.

The insurer contends that, because Dr. Snow relied on a contrary history, his opinion is not reliable. In particular, the insurer asserts that Dr. Snow relied on a history that claimant's symptoms following the MVA were limited to the left side and that symptoms after August 30, 1993 were solely right-sided and that such a history is not supported by the record.

The insurer's argument would be well-taken if the record were limited to Dr. Snow's letter to claimant's attorney. However, based on Dr. Snow's deposition testimony, we find that his opinion is most reasonably construed as being based on a history that the severity of claimant's right-sided symptoms were much greater in August 1993 than any exhibited during treatment for MVA injuries. Furthermore, based on his deposition, we find that Dr. Snow relied on a history that claimant's symptoms had largely abated by July 1993, then subsequently dramatically increased with heavier work.

This understanding of claimant's history is supported by the record. Moreover, we consider Dr. Snow's opinion to be well-reasoned. Therefore, we agree with the Referee that Dr. Snow's opinion is persuasive and carries claimant's burden of proving that her work activities were the major contributing cause of her right upper back and shoulder condition. See ORS 656.802(2).

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

ORDER

The Referee's order dated April 12, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
JOHN R. JOHANSON, Claimant
Own Motion No. 94-0705M
OWN MOTION ORDER
Jon Correll, Claimant Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable right knee injury. Claimant's aggravation rights expired on December 9, 1990. The employer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

The employer initially requested Director review of claimant's proposed surgery, and the Director ordered that the employer was not required to reimburse claimant for the proposed surgery, if rendered. Claimant requested a hearing on the matter of the reasonableness and necessity of the proposed surgery. (WCB 93-10812). On March 18, 1994, Referee Baker issued an Opinion and Order in which he ordered the employer to provide the right total knee arthroplasty in question. The employer requested Board review of Referee Baker's order, and on November 15, 1994, the Board affirmed the Referee's 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.

On May 27, 1993, Dr. Bert, claimant's treating orthopedist, requested authorization to perform a total knee arthroplasty of claimant's right knee. Thus, we conclude that, as of May 27, 1993, claimant's compensable condition worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force if he or she is: (1) engaged in regular gainful employment; (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).

The employer contends that claimant is not in the work force. We agree. Claimant was presumably working at the time of the May 27, 1993 request for surgical authorization. However, claimant subsequently applied for retirement, with a retirement date of October 28, 1993. As of March 18, 1994, the issuance date of Referee Baker's order, the total knee arthroplasty proposed by Dr. Bert had not been performed. Inasmuch as temporary disability compensation is authorized under the

Board's own motion jurisdiction only from the time of surgery or hospitalization, see ORS 656.278(1)(a), we find that the "date of disability," for the purpose of determining whether claimant is in the work force, is the date he enters the hospital for the proposed surgery. If claimant has voluntarily removed himself from the work force prior to the date of disability, no work time is missed, and no temporary disability compensation is due. See Dawkins v. Pacific Motor Trucking, supra; Weyerhaeuser v. Kepford, supra.

Claimant has the burden of proof on this issue. See ORS 656.266. Claimant has not responded to the employer's contention that he is not in the work force. In fact, the record shows that claimant applied for retirement effective October 1993, and he offers no evidence that he has reentered the work force.

On the record, claimant has failed to prove he is in the work force. Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if the required evidence is forthcoming within 30 days after 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.

December 15, 1994 Cite as 46 Van Natta 2464 (1994)

In the Matter of the Compensation of
RICK D. OBER, Claimant
WCB Case No. 93-14725
ORDER ON REVIEW
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee Holtan's order that upheld the self-insured employer's partial denial of claimant's headache condition. On review, the issue is compensability.

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

The only evidence supporting the compensability of claimant's headache condition is claimant's testimony that he had constant headaches since the 1990 compensable injury. No physician has causally related claimant's headache condition to the July 26, 1990 injury. We conclude that the causation of claimant's headache condition presents a complex medical question which requires, for its resolution, expert medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993); Uris v. Compensation Dept., 247 Or 420 (1967).

In Barnett, supra, the court listed five relevant factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether the symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence.

Here, we find the situation complicated. Claimant was compensably injured on July 26, 1990. The claim was accepted by the employer for a head laceration and cervical strain. Although claimant reported the July 1990 injury immediately, he did not seek treatment for his headache symptoms until April 28, 1992, almost two years after the July 1990 compensable injury. In addition, although claimant testified to daily headaches from the date of the July 1990 injury, this testimony is not supported by the contemporaneous medical records. Finally, there are the opinions of four physicians in the record who were unable to relate the headaches causally to the injury.

Under the circumstances, we conclude that causation of the headache condition is a complex medical question and that medical evidence is necessary to establish compensability of the headache condition. Barnett v. SAIF, supra; Uris v. Compensation Dept., supra. Inasmuch as the record contains no medical evidence causally relating claimant's headache condition to the compensable injury, we conclude that claimant has not established compensability. Claimant's testimony alone is insufficient to carry his burden. For these reasons, and the reasons given by the Referee, we find the claim not compensable.

ORDER

The Referee's order dated April 19, 1994 is affirmed.

December 15, 1994 Cite as 46 Van Natta 2465 (1994)

In the Matter of the Compensation of
DOUGLAS L. TYREE, Claimant
WCB Case No. 93-03679
SECOND ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On November 16, 1994, we issued an Order on Reconsideration which awarded claimant an additional 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). As a result of our decision, claimant's total award was increased from 2 percent (3 degrees), as granted by an Order on Reconsideration and affirmed by a Referee's order, to 7 percent (10.5 degrees). Contending that we neglected to grant a 5 percent award for his left forearm (wrist), claimant seeks reconsideration.

In reaching our determination regarding the extent of claimant's permanent disability, we relied on the opinion provided by his attending physician, Dr. Panum. Noting that claimant suffered from "bilateral hand pain," Dr. Panum concluded that claimant had permanent limitations of no repetitive hand work and no tight grasping using his hands. (Ex. 17). Based on this opinion, we found that claimant was entitled to a 5 percent chronic condition award under former OAR 436-35-010(6).

Notwithstanding our reliance on Dr. Panum's opinion, we confined our award to claimant's right forearm (wrist). After further consideration of the record, we find that claimant is also entitled to a 5 percent chronic condition award for his compensable left forearm (wrist) condition.

Consequently, in addition to the "right forearm (wrist)" scheduled permanent disability award granted in our November 16, 1994 Order on Reconsideration, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist). As with our prior order, claimant's counsel is awarded 25 percent of this increased compensation, provided that the total "out-of-compensation" attorney fee award does not exceed $3,800.

Accordingly, we withdraw our November 16, 1994 order. On reconsideration, as modified and supplemented herein, we republish our November 16, 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
MICHAEL J. VAN PATTEN, Claimant
WCB Case No. 94-04822
ORDER ON REVIEW
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests Board review of Referee McCullough's order that dismissed his hearing request concerning the insurer's March 31, 1994 "back-up" denial of his back injury claim. On review, the issue is the propriety of the Referee's dismissal order.

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

The procedural background regarding this case is set forth in our October 3, 1994 Order of Dismissal in WCB Case No. 93-13778. Additional information is provided in the Board's July 15, 1994 Order Approving Claim Disposition Agreement (CDA). By this reference, we incorporate those prior orders into this order.

Subsequent to the filing of claimant's hearing request from the insurer's "back-up" denial, the parties entered into an amended CDA. Pursuant to the CDA, the insurer agreed to withdraw its "back-up" denial and claimant (then represented by counsel) agreed to withdraw his hearing request from that denial. The Board approved the CDA on July 15, 1994.

On July 22, 1994, in accordance with the approved CDA, the Referee dismissed claimant's hearing request. The Referee reasoned that the dispute raised by claimant's hearing request had been resolved pursuant to the CDA. Thereafter, claimant, pro se, requested Board review of the Referee's July 22, 1994 dismissal order in "WCB Case No. 94-04822."

We find no error in the Referee's decision. Claimant's hearing request arose from the insurer's "back-up" denial. That denial, as well as claimant's hearing request, were expressly withdrawn under the parties' approved CDA. Inasmuch as the issue raised by claimant's hearing request had been resolved, and because claimant had withdrawn his hearing request, the Referee's dismissal order was proper.

ORDER

The Referee's order dated July 22, 1994 is affirmed.

In the Matter of the Compensation of
DARRON A. ARNOLD, Claimant
WCB Case No. 93-04313
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

FINDINGS OF FACT

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

In lieu of the fifth paragraph on page 2 of the Referee's Opinion and Order, we make the following findings.

Claimant obtained permission from co-worker Do to use the employer's equipment and paint which were assigned to Do.

Claimant used the paint, equipment, and air supply respirator assigned to Do during his (claimant's) l0:30 p.m. break for the purpose of painting his own helmet in the paint booth. (Ex. 17, 22-14 to -15; Tr. 30).

We do not adopt the Referee's findings of ultimate fact. Instead, we make the following findings of ultimate fact.

The employer acquiesced in claimant's use of the employer's sanding and priming material and equipment for working on personal property on March 15, 1993.

The employer did not acquiesce in claimant's use of its paint and painting equipment to paint his personal property on March 15, 1993.

Claimant's work-related exposures were the major contributing cause of his respiratory and neurological conditions on and after March 15, 1993.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's exposures on March 15, 1993, while priming and painting his personal property did not occur in the course and scope of his employment. We agree that claimant's exposure while painting his personal property did not occur in the course and scope of his employment, based on the following reasoning.

It is claimant's burden to establish that his occupational disease arose out of and in the course of his employment. ORS 656.266; 656.802(1). To do so, claimant must prove that his injury is sufficiently work-related to be compensable, under the unitary work-connection test adopted by the Oregon Supreme Court. See Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994); Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 572, 575, rev den 300 Or 249 (1985).

In determining whether an activity is sufficiently work-related, we consider the following factors: (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 of his own. Mellis, supra, 74 Or App at 574. While all seven factors are considered, no one factor is dispositive. Id.

Claimant is employed as a painter's helper. His regular duties involve preparing trucks for painting, which includes taping, sanding and spraying primer. (Tr. 14). As a painter's helper, he is not allowed to "shoot" color paint in the paint booth. (Id., Tr. 20). On March 15, 1993, claimant sanded, primed and painted his personal property, a motorcycle helmet, during the course of his regular work day. (Tr. 24, 29-30, 176-77). The following day he sought treatment for respiratory and other symptoms associated with hydrocarbon exposure. (Ex. 1).

The issue in this case is whether all of claimant's workplace exposure on March 15, 1993 "arose out of" his employment, including that portion of the exposure attributable to working on his personal property. Specifically, the question we must decide is whether claimant's activities working on his helmet arose out of and in the course of his employment. To make that determination, we evaluate the seven Mellis factors identified above.

Benefit to Employer

Claimant's activities in sanding, priming and painting his own motorcycle helmet did not benefit the employer.

Activities Contemplated by Employer and Employee

Claimant's regular duties included sanding and priming. The employer has a policy and practice of allowing employees to have personal work done during regular work hours, with a work order. (Tr. 53-57, 86-87, 110, 125-26). Typically, the person responsible for performing a specific task would also perform the same task on a personal project, and charge the time accordingly on a work order. (Tr. 142). Under these circumstances, we conclude that claimant's activities sanding and priming his personal helmet were contemplated by the employer and employee.

However, claimant's job duties specifically did not include painting. Claimant knew that he was not authorized to paint, and he had been previously warned to not enter the paint booth without proper authorization. (Tr. 20, 73-74). Claimant received a disciplinary warning for entering the paint booth without authorization. (Ex. 25a). Accordingly, we conclude that claimant's activity painting his helmet in the paint booth was not a mutually contemplated activity.

Ordinary Risk of, or Incidental to, Employment

Claimant's exposures while sanding and priming were an ordinary risk of his employment, whereas the exposure while painting his helmet was not. However, claimant also testified that he regularly entered the paint booth throughout the day (up to 5 times per day) while spray painting was going on in order to obtain touch up paint for his own assigned work duties. (Tr. 172-73, 182-83). Although some employees testified that no one was allowed to enter the paint booth until after the paint spray had dissipated, co-worker Rea and painter Do both confirmed that painter's helpers did enter the booth while spraying was going on. (Compare Tr. 90, 151-53 with Tr. 104, 160). Claimant testified that he first learned that he was not allowed to enter the paint booth when he returned to work after the March 15, 1993 exposure. (Tr. 181). Under these circumstances, we conclude that some limited paint spray exposure in the paint booth was an ordinary risk of claimant's employment on the date of exposure.

Paid for Activity

The record does not establish whether claimant was paid for the activities involving work on his helmet. However, because claimant worked on his helmet during regular working hours and a regularly-scheduled break, we assume that claimant was paid for these activities.

Employer's Premises

Claimant's activities concerning his own helmet took place on the employer's premises.

Activities Directed, or Acquiesced in, by Employer

Inasmuch as claimant did not obtain a work order, we do not find that the employer directed claimant to perform the activities associated with his helmet.

However, both claimant's foreman Kuhn and his supervisor Allen knew that claimant wanted to work on a personal project. (Tr. 28-29, 70, 124-25). Neither one directed him to first obtain a work order, and neither one prohibited him from working on his helmet. (Id). Moreover, the record establishes a practice of employees doing personal work without work orders. (See Tr. 35, 53-55, 127-29, 161-66). Indeed, both claimant's supervisor Allen and another co-worker admitted having personal work done without a work order. (See Tr. 76, 81-82, 143-44). Moreover, although witnesses mentioned the employer's policy of requiring work orders, no one, not even the employer's personnel manager, could identify where the policy was posted, or if it was posted at all. (See e.g., Tr. 118, 143). Allen admitted giving claimant permission to sand his helmet, but he denied giving him permission to paint the helmet. (Tr. 81).

Under these circumstances, we conclude that the employer acquiesced in claimant working on his helmet without a work order. However, we find that the acquiescence extended only to sanding and priming his helmet; it did not extend to painting the helmet in the paint booth. See Chris T. Singelstad, 46 Van Natta 894 (1994) (employer acquiesced generally in claimant's workplace use of chainsaw); Bob E. Grotz, Deceased, 45 Van Natta 1653 (1993) (employer did not acquiesce in employee's borrowing equipment where no pattern of borrowing shown, and where no one authorized to give permission knew that claimant borrowed equipment).

Personal Mission

Inasmuch as claimant's work on his own helmet did not benefit the employer, and claimant did not follow the employer's policy of obtaining a work permit for his personal project, we conclude that claimant was on a personal mission while he was working on his helmet.

Conclusion: All Factors Evaluated

Considering all the above factors, without any one factor being dispositive, we are persuaded that claimant's activities in sanding and priming his helmet did arise out of his employment. We note in particular that although claimant's work on his helmet was a personal mission, we conclude that the employer acquiesced in its employees' activities on personal projects, at least to the extent those activities were part of the employee's regular duties, even without first obtaining a work order.

However, with respect to claimant's activities in painting his helmet, we come to a different conclusion. Claimant knew he was not authorized to paint in the paint booth. We are not persuaded that claimant's supervisor authorized him to paint his helmet in the paint booth. The evidence does not establish a general practice of employees working outside the scope of their regular duties. Under these circumstances, we conclude that the employer did not acquiesce in claimant painting his helmet in the paint booth.

Accordingly, we conclude that claimant's primer exposures on March 15, 1993 were work-related, while his paint exposures were not.

Medical Evidence

It is claimant's burden to establish that work-related exposures were the major contributing cause of his respiratory condition. After our review of the record, we conclude that the preponderance of medical evidence establishes that claimant's work-related exposures were the major contributing cause of his respiratory condition.

Claimant relies primarily on the opinion of his treating physician, Dr. Kendregan. Dr. Kendregan opines that claimant's condition -- an acute irritation of his airways -- was caused by exposure to "Variprime" primer spray. (Ex. 30-3). He bases his opinion on a detailed history of events and progression of symptoms on March 15, 1993. (See Ex. 30). He specifically rules out paint exposure as a cause, because claimant's symptoms began before his paint exposure during the 10:30 p.m. break. (Ex. 30-3). Dr. Kendregan concludes that, because of the temporal relationship between claimant's exposure and the onset of his medical problems, claimant's workplace exposure was the major contributing cause of his disability and need for treatment. (Exs. 34).

We do not find Dr. Kendregan's opinion persuasive, because we do not find it to be based on an accurate history. In claimant's initial descriptions of the events of March 15, 1993 and the following day, claimant placed the onset of his symptoms around 11-11:30 p.m. and after his shift ended at 12:30 a.m. Only later did claimant claim he had symptoms before painting his helmet at 10:30 p.m. Claimant does not persuasively explain the discrepancy. Accordingly, we conclude that the history claimant provided shortly after the injurious event is more reliable than later versions, including the version Dr. Kendregan relies on in his August 10, 1993 report. (Ex. 30). Therefore, we are not persuaded by Dr. Kendregan's opinion that paint exposure did not cause claimant's need for medical treatment.

Because we find that Dr. Kendregan's report is based on a materially inaccurate history, we do not find his opinion persuasive.

Dr. Montanaro, who examined claimant at the employer's request, opined that work exposure was "the material contributing cause" of claimant's need for medical treatment. (Ex. 28-6). Unlike Dr. Kendregan's opinion, Dr. Montanaro's opinion does not focus on a specific history of exposures on March 15, 1993. Instead, Dr. Montanaro opined that claimant's exposure to particulates, as well as volatile organic substances, on March 15, 1993 was the material contributing cause of his need for medical treatment at that time. (Ex. 28-6). Dr. Montanaro identified the specific substances of concern as the volatile organic substances found in the Variprime primer and Freightliner blend #5, as well as the particulate matter generated by sanding. (Id). These are all substances to which claimant was exposed throughout his work day as he performed his assigned duties as a painter's helper.

We acknowledge that Dr. Montanaro opined that work exposure was the "material" contributing cause of claimant's condition. However, Dr. Montanaro does not identify any other contributing causes of claimant's respiratory and neurological condition. "Magic words" are not required to establish the requisite causal relationship. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Accordingly, we conclude, relying on Dr. Montanaro's opinion, that claimant's workplace exposures on March 15, 1993 were the major contributing cause of his respiratory and neurological 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 counsels' services at hearing and on review concerning the compensability issue is $6,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, claimant's counsels' statements 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.[1]

ORDER

The Referee's order dated January 10, 1994 is reversed. The self-insured employer's April 1, 1993 denial is set aside, and the claim is remanded to the employer for processing in accordance with law. Claimant's attorney is awarded $6,000 for services at hearing and on Board review, to be paid by the self-insured employer.

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[1] We note that a different attorney represented claimant at hearing. Attorney fee petitions from both attorneys have been submitted for our consideration, and claimant's former counsel has asserted an "attorney fee lien" for his services at hearing. We decline claimant's counsel's request for an apportionment of the fees. See Gabriel Zapata, 46 Van Natta 403, 405 n.1 (1994) (manner in which the fee is shared by claimant's current and former counsel is a matter to be decided between the two of them, not by this forum). In other words, we award one attorney fee payable by the employer to claimant's current attorney of record (the attorney who represented claimant on review). The particular manner in which that fee will be subsequently distributed between claimant's current and former attorney is a matter between them to decide.

In the Matter of the Compensation of
AHMAD F. MINZALGI, Claimant
WCB Case No. 94-00393
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Neal's order that: (1) upheld the self-insured employer's partial denial of claimant's low back, left hip, and left leg condition; and (2) declined to assess penalties and attorney fees for the employer's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

At hearing, Exhibits B through N, 1 through 38, 26A, 27A and 27B were admitted into evidence.

On review, claimant contends that compensability turns on credibility. Specifically, claimant asserts that he is credible; that because he is credible, the history he gave to Dr. Aversano in November 1993 is accurate; and that the Board must, therefore, defer to Dr. Aversano's accurate opinion that claimant's low back, left hip, and left leg condition is the result of the April 1993 work injury. Noting that the Referee made no express credibility finding, claimant asks the Board to make the necessary credibility finding based on the substance of his testimony at hearing, not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The Referee found that claimant had not sustained his burden of proof that he injured his low back, hip and leg during the April 1993 work injury. In reaching his conclusion, the Referee found it "unlikely" that the various physicians who initially treated claimant would "neglect" to mention the back, leg and hip pain complaints claimant testified he expressed to those physicians. Accordingly, because Dr. Aversano's opinion was based upon claimant's history alone, and not on a review of claimant's medical records, the Referee declined to rely on it.

Although the Referee made no express credibility finding, we find that the Referee, by disregarding claimant's testimony and declining to rely on Dr. Aversano's opinion (which was based on claimant's reporting to the doctor), implicitly found claimant's testimony to be not credible. See Erck v. Brown Oldsmobile, 311 Or 519, 527 n.7 (1991).

Were we to make a credibility finding, we would find claimant not to be a credible or reliable historian. In this regard, we note that we are unable to reconcile the inconsistencies in claimant's testimony and his history to Dr. Aversano with his prior reporting to Drs. Jackson, Berecz and Mihelic. We are more persuaded by claimant's prior statements made in conjunction with the receipt of medical treatment in April and May 1993 than we are persuaded by his testimony at hearing to determine compensability. Moreover, claimant's inconsistent statements reduce the persuasiveness of Dr. Aversano's opinion which necessarily relies upon the accuracy of claimant's history. Consequently, as did the Referee, we would instead accept the opinion of Dr. Mihelic that claimant's November 1993 condition was "new," and not related to the April 1993 work injury.

ORDER

The Referee's order dated April 6, 1994, as reconsidered April 28, 1994, is affirmed.

In the Matter of the Compensation of
ROBERT T. ORTEZ, Claimant
WCB Case No. 93-05172
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Crumme's order which upheld the self-insured employer's denial of claimant's occupational disease claim for a stress-related mental disorder. On review, the issue is compensability.

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

The Referee found that the employment conditions producing claimant's mental disorder were conditions generally inherent in every working situation and were reasonable disciplinary, corrective or job performance evaluation actions by the employer. ORS 656.802(3)(b). Relying on the opinions of Dr. Parvaresh and Dr. Davies, the Referee concluded that claimant had failed to prove, by clear and convincing evidence, that work-related stressors, other than those excluded above, were the major contributing cause of his mental disorder. We agree.

Because we agree with the Referee that the employer's disciplinary actions were reasonable, those actions are excluded under ORS 656.802(2)(b) and may not be considered in the analysis of the compensability of the claim. However, the existence of reasonable disciplinary actions does not necessarily equate with a failure of proof. Brenda K. Allen, 44 Van Natta 2476 (1992). Thus, claimant must establish by clear and convincing evidence that the work environment, including alleged conflicts with and alleged harassment by Mr. Alvarez (his supervisor), were the major contributing cause of his mental disorder. Id.

Dr. Parvaresh's opinion establishes that claimant's alleged harassment did not exist in a real and objective sense. ORS 656.802(3)(a). Dr. Parvaresh reported that claimant's MMPI results indicated that claimant had difficulty in terms of how he related to others and perceived what was really going on around him. Thus, claimant's perceived harassment could be explained based on his personality make-up and how he perceived his environment as a whole. Based upon his clinical examination and review of claimant's personnel file, Dr. Parvaresh opined that claimant's problems were related to poor performance and shortcomings on the job, and because claimant felt he was the only one victimized. (Ex. 8; Tr. 233-34, 245, 247).

Dr. Parvaresh also attended the hearing and observed the testimony of the lay witnesses describing the environment at work. He testified that the problems that claimant had with his supervisor occurred in the course of disciplinary action and that claimant probably would not have sought treatment independent of the disciplinary action and his feeling of being harassed. (Tr. 252-53). He concluded that the disciplinary actions, rather than Mr. Alvarez' management style, were the cause of claimant's mental disorder. (Tr. 255-56).

Dr. Davies obtained a history that claimant attributed all of his emotional problems to his relationship with Mr. Alvarez. He noted that the two had a personality clash from the outset that grew more intense over time. Dr. Davies found that claimant overreacted to Mr. Alvarez' habits, that claimant was a difficult employee to supervise, and that claimant had a limited tolerance of others whom he found unacceptable. Dr. Davies based his findings, in part, on the result of MMPI tests which indicated, inter alia, that claimant had a self-destructive or self-defeating personality, that he tended to be very tense and overcontrolled, and that his perceptions were subject to distortion. (Tr. 345-349). Based on a review of claimant's personnel records, Dr. Davies felt that the disciplinary procedures were handled in a progressive and fair fashion. He opined that claimant was agitated over a relationship conflict with his supervisor and termination. (Ex. 9; Tr. 355). After attending the entire hearing, Dr. Davies concluded that the disciplinary actions leading to claimant's termination were the cause for claimant to seek treatment. (Tr. 357).

We find that the persuasive medical evidence establishes that claimant's alleged stressors were related to reasonable discipline and corrective performance evaluation actions.[1] In addition, we find that the efforts expended by claimant's employer to improve business operations (even if those efforts created conflict/stress) are conditions generally inherent in every working situation. Therefore, we conclude that the allegedly stressful employment conditions were conditions generally inherent in every working situation and were also reasonable disciplinary, corrective actions by the employer. Accordingly, claimant has failed to establish the compensability of his mental disorder claim. See Dana Lauzon, 43 Van Natta 841 (1991)(if the claimant fails to establish any one of these elements, the occupational disease claim for a stress-related mental disorder fails).

ORDER

The Referee's order dated March 7, 1994 is affirmed.

[1] We agree with and adopt the Referee's reasoning finding Dr. Dixon's opinions unpersuasive.

December 19, 1994 Cite as 46 Van Natta 2473 (1994)

In the Matter of the Compensation of
KURTIS L. HAERTLING, Applicant
WCB Case No. CV-94009
ORDER ON RECONSIDERATION (CRIME VICTIM ORDER)
Dean Heiling, Attorney
Mary H. Williams, Attorney

On November 21, 1994, Special Hearings Officer Martha J. Brown issued Findings of Fact, Conclusions and a Proposed Order modifying the Department of Justice's September 19, 1994 Order on Reconsideration which had denied applicant's claim for benefits under the Crime Victim Compensation Act. Specifically, Hearing Officer Brown found that: (1) applicant was a victim of a compensable crime; (2) applicant's acts or conduct contributed to his injuries; and (3) his award of compensation under the Act should be reduced by 50 percent.

Applicant has requested reconsideration. Asserting that his actions were not improper and that his conduct did not justify his assailant's violent response, applicant asks that he receive 100 percent of the benefits to which he is entitled under the Act.

After conducting our review of the record, we agree with Hearing Officer Brown's conclusion that the response from applicant's assailants was extreme and unjustified. Nevertheless, we likewise concur with Hearing Officer Brown's findings that applicant's conduct contributed to his injuries to the extent that his compensation award should be reduced by 50 percent.

Accordingly, on reconsideration, as supplemented herein, we adopt Hearing Officer Brown's November 21, 1994 order.

IT IS SO ORDERED.

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

This matter is before the Board on remand from the Court of Appeals. SAIF v. Kelly, 130 Or App 185 (1994). The court has reversed our prior order, Joseph E. Kelly, 45 Van Natta 313 (1993), which found the SAIF Corporation, rather than Kemper Insurance Company (Kemper), responsible for claimant's left elbow and right wrist conditions. Specifically, the court has directed us to reconsider or explain our decision concerning our application of the "last injurious exposure rule."

FINDINGS OF FACT

We republish the findings of fact contained in our February 24, 1993 Order on Review, except for the second paragraph of the "Findings of Ultimate Fact."

In addition, we find that claimant first sought and received treatment for symptoms of his compensable left elbow and right wrist conditions in 1990, while working for Kemper's insured.

CONCLUSIONS OF LAW AND OPINION

The Referee determined that Kemper (the insurer for the prior employer), rather than SAIF (the insurer for the subsequent employer), was responsible for claimant's left elbow and right wrist conditions. The Referee reasoned that claimant's occupational disease claim against SAIF was not compensable.

On review, we reversed. Joseph E. Kelly, supra. To begin, under the last injurious exposure rule of proof, we found the conditions compensable. Turning to the responsibility determination, we applied the last injurious exposure rule and concluded that the onset of disability arose on February 12, 1991, when claimant first sought treatment for his left elbow and right wrist conditions. Inasmuch as SAIF was providing coverage at that time, we assigned initial responsibility to SAIF. Finally, finding that SAIF had not established that claimant's work exposure with its insured could not have caused these conditions or that his prior employment with Kemper's insured was the sole cause, we held that responsibility remained with SAIF.

Relying on Bracke v. Baza'r, 293 Or 239, 248 (1982) and Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994), the Kelly court reiterated that the dispositive date for assigning responsibility is the date claimant first sought treatment for symptoms of the claimed conditions (even though the conditions were not diagnosed until claimant began working for a different employer). Unable to determine whether we found that claimant sought medical treatment for symptoms of his subsequently diagnosed left elbow and right wrist conditions while employed by Kemper's insured, the court reversed and remanded for reconsideration. Accordingly, after receiving and considering supplemental briefs from Kemper and SAIF, we proceed with our reconsideration.

The parties agree that the "last injurious exposure rule" applies to this responsibility dispute. Under the rule, the "onset of disability" is the triggering date for initial assignment of responsibility. See Bracke v. Baza'r, supra. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, supra. The dispositive date is the date claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, supra at 188.

In this case, Kemper urges us to find that claimant did not have "continued" or "increased" left elbow symptoms or any indication of right de Quervain's tenosynovitis during its coverage. Kemper contends that claimant had few, if any, symptoms in early 1990 which could reasonably be attributed to

his current left and right upper extremity problems.[1] Thus, Kemper argues that claimant's lack of right thumb symptoms while it was on the risk, and the June 1990 "normal" ulnar nerve findings, establish that the dispositive symptoms were a recent development during SAIF's coverage. We disagree.

The record reveals that claimant began treating with Dr. Gill for pain in both elbows in April 1990, while employed at Kemper's insured. (Ex. 1). Claimant also had pain in both wrists. (Ex. 9). Dr. Gill eventually diagnosed bilateral carpal tunnel syndrome (CTS) and performed a bilateral carpal ligament release. (Exs. 9, 10). Following the September 21, 1990 surgery, claimant continued to have right wrist and left elbow pain, for which he sought treatment.

On February 12, 1991, Dr. Gill diagnosed left ulnar nerve irritability and right De Quervain's tenosynovitis as separate and distinct from the bilateral CTS. (Ex. 22). With the benefit of hindsight, Dr. Gill opined that claimant's left ulnar nerve irritability and right De Quervain's tenosynovitis conditions arose during claimant's employment with Kemper's insured. (Exs. 22, 29).

Dr. Gill observed and recorded that claimant suffered left elbow and right wrist symptoms in 1990. (Exs. 11, 12, 13, 14). Although he did not arrive at the current diagnoses in 1990, Dr. Gill ultimately concluded that the conditions arose during Kemper's coverage. There is no medical evidence challenging Dr. Gill's firsthand observations or his conclusions. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, we find that claimant sought and received treatment for symptoms of his current conditions before he started working for SAIF's insured.[2] (See Exs. 11, 12, 13, 14, 15, 29).

In addition, upon reconsideration, we conclude that responsibility is initially assigned with Kemper because claimant first sought and received treatment for his compensable left elbow and right wrist symptoms during his employment with Kemper's insured. In order to shift responsibility to a later carrier, Kemper must show that claimant's later employment actually contributed to a worsening of his compensable conditions. Timm v. Maley, supra; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 or App 461, 465 (1988).

Here, Dr. Gill, treating physician, opined that "the vast majority, if not all" of claimant's upper extremity problems result from his work activities for Kemper's insured. (Ex. 30-2). This opinion is uncontroverted. Thus, because Kemper has not established that claimant's later employment for SAIF's insured actually contributed to a worsening of these problems, Kemper remains responsible for claimant's compensable left elbow and right wrist conditions.

Accordingly, on reconsideration, the Referee's order dated August 19, 1991 is affirmed. Further, we republish that portion of our February 24, 1993 order that awarded claimant's counsel a $250 attorney fee, except that the fee is payable by Kemper, the responsible insurer. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] On the other hand, Kemper acknowledges that 1989 test results were suggestive of an early left ulnar neuropathy, a condition which developed and progressed thereafter. (See Exs. B-4, 23-1).

[2] As we stated in our prior order, Dr. Gill did not identify and diagnose claimant's current left elbow and right wrist conditions until February 12, 1991, during SAIF's coverage. However, as the court has previously noted, the date of diagnosis is not dispositive.

In the Matter of the Compensation of
CHARLES E. PILGREEN, Claimant
Own Motion No. 94-0755M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on October 24, 1991. The employer voluntarily reopened claimant's claim for the payment of temporary disability compensation pursuant to ORS 656.278. The employer asks the Board to authorize the reopening of claimant's claim.

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

No recommendations for surgery or hospitalization are in the record. Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant the employer's request. Accordingly, we deny the request for own motion relief. Id.

The employer's gratuitous payment of temporary disability compensation is permitted by statue and is within the employer's discretion. See ORS 656.278(4); Allen E. Orton, 42 Van Natta 924 (1990). However, inasmuch as those benefits were not properly paid pursuant to the Board's Own Motion authority, the Board shall not authorize the reopening of the claim. ORS 656.278(1)(a).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY C. RAY-SCHAERTL, Claimant
WCB Case No. 93-11232
ORDER ON REVIEW
Bottini & Bottini, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Podnar's order that: (1) set aside its denial of claimant's aggravation claim for a cervical condition; and (2) set aside its "de facto" denial of claimant's current psychological condition. On review, the issues are aggravation and compensability. We affirm.

FINDINGS OF FACT

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

In lieu of the third to last paragraph on page 3 of the Opinion and Order, we find: Before her 1992 work-related cervical injury, claimant's multiple personality disorder was at least partially resolved following a three-year course of treatment with clinical social worker Robert Stevens.

We also find that, following claimant's January 30, 1992 cervical injury at work, the employer accepted a disabling neck strain. (Ex. 2).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions and Opinion, with the following supplementation.

To establish a compensable worsening, claimant must show, inter alia, increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986). We conclude that claimant has met that burden.

Before claim closure, claimant was able to work without limitation. (Exs. 19-6, 21, 22). Following claim closure, Dr. Hills, one of claimant's treating physicians, released her from work due to a worsening of her cervical symptoms, as manifested by increased pain and decreased range of motion. (Exs. 37, 40, 41, 42, 44A, 52, 57). Claimant has not worked since then. (Tr. 22). Hills concluded that, following claim closure, claimant was less able to work than she was at claim closure. (Ex. 40). Dr. Kemple, another of claimant's treating physicians, also concluded that claimant currently probably was not employable. (Ex. 75-1).[1]

Under the circumstances, we find that this evidence shows that, following the worsening in her cervical condition, claimant was no longer able to perform the same work she was able to perform before claim closure. Accordingly, we conclude that claimant's worsened cervical condition resulted in a diminished earning capacity.

The employer argues that claimant's aggravation claim fails because she did not establish that her current cervical symptoms are more than a waxing and waning of symptoms contemplated by the March 1993 Determination Order, which closed the claim with an 11 percent unscheduled permanent disability award. We disagree.

Because claimant received a previous permanent disability award for her cervical condition, to establish a compensable aggravation she must prove that any worsening is more than a waxing and waning of symptoms contemplated by the disability award. ORS 656.273(8). Here, there is no contemporaneous medical report establishing that claimant's permanent disability award contemplated future waxing and waning of cervical symptoms. Consequently, it is unnecessary to determine whether claimant's current symptoms exceeded any contemplated fluctuating symptoms. See ORS 656.273(8); Daniel C. Reddekopp, 46 Van Natta 1536 (1994).

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 is $1,000, to be paid by employer. 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 23, 1994 is affirmed. For services on review, claimant's counsel is awarded $1,000, to be paid by the self-insured employer.

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[1] Dr. Kemple reported that claimant's diminished earning capacity was partly related to her "injury/aggravation", and partly related to other causes. (See Ex. 75-1). The employer argues that claimant's aggravation claim fails because she has not proved that her aggravation was the major contributing cause of her inability to work. In view of the fact that the employer does not contest causation, we reject that argument. In any event, the major contributing cause standard does not apply in an aggravation context absent a contention that the claimant's current condition is a consequential or resultant condition, ORS 656.005(7)(a)(A), (B), or an assertion by the carrier that an off-work injury caused the current condition. ORS 656.273(1); see Terry K. Knowles, 46 Van Natta 1214 (1994). None of those contentions apply to this case.

In the Matter of the Compensation of
GENE T. BURR, Claimant
WCB Case No. 93-00776
ORDER OF ABATEMENT
Emmons, Kropp, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

On November 21, 1994, we issued an Order on Review that affirmed a Referee's order that upheld the self-insured employer's denial of claimant's occupational disease claim for left ear hearing loss. Asserting that our decision contains factual errors, claimant seeks reconsideration.

In order to further consider this matter, we withdraw our November 21, 1994 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA K. CLAFLIN, Claimant
WCB Case Nos. 93-15045 & 93-05422
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Alexsis Risk Management (Alexsis), on behalf of Container Corporation, requests review of those portions of Referee Mills' order that: (1) set aside its responsibility denial for claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); and (2) upheld the Kemper Insurance Company's (Kemper's) responsibility denial, on behalf of Horizon Air, for the same condition. In her brief, claimant asserts that she is entitled to an attorney fee award pursuant to ORS 656.386(1). On review, the issues are responsibility 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

Claimant first sought medical treatment for her bilateral CTS on January 13, 1993, when Kemper was on the risk. She began employment with Container Corporation (Alexsis) in July 1993. Claimant has not been disabled from work. Neither employer had accepted her claim at the time of hearing.

Relying on Fred A. Nutter, 44 Van Natta 854 (1992), the Referee applied the last injurious exposure rule to make an initial assignment of responsibility to Alexsis on the basis that the onset of disability established that it was the last potentially causal employment. We affirm the Referee's opinion, but with the following supplemental reasoning.

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. Fred A. Nutter, supra. In such cases, we apply 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).

If, as here, a claimant received treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396 (1993).

Here, claimant first sought treatment for her carpal tunnel syndrome on January 13, 1993, when Kemper was on the risk. Therefore, Kemper is initally assigned responsibility for claimant's carpal tunnel condition.

In order to shift responsibility to a later carrier, the initially responsible carrier must show that a later employment independently contributed to a worsening of the condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988).

Here, we agree that the medical evidence unequivocally supports the Referee's conclusion that claimant's work at Container Company was the major contributing cause of a pathological worsening of claimant's CTS condition. (See Exs. 14, 16, 17 and 19). Thus, we find that claimant's work activities with Container Corporation independently contributed to the worsening of claimant's CTS condition. Consequently, responsibility for claimant's CTS condition shifts from Kemper to Container Corporation.

Attorney Fees

Claimant asserts an entitlement to an attorney fee award pursuant to ORS 656.386(1).[1] Neither carrier contests claimant's entitlement to a fee under that statute, which authorizes an award of attorney fees if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held[.]"

Here, claimant filed a claim for bilateral carpal tunnel syndrome with Kemper. Kemper initially denied compensability for the claim. (Ex. 8). Claimant, pro se, filed a request for hearing on the compensability denial. Claimant then retained an attorney to represent her in the matter. Kemper then denied responsibility. Claimant's attorney filed a supplemental request for hearing on compensability, among other issues. Three days prior to hearing, Kemper withdrew its compensability denial. (Tr. 3).

We conclude that, on this record, counsel's supplemental request for hearing was sufficiently instrumental to serve as the basis of an attorney fee award pursuant to ORS 656.386(1). See Gates v. Liberty Northwest Ins. Corp., 131 Or App 164 (1994); Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant's counsel entitled to carrier-paid fee under ORS 656.386(1) when carrier rescinded compensability portion of denial before hearing regarding responsibility for claim); see also Kerry L. VanWagenen, 46 Van Natta 1786 (1994) (Request for hearing preserved claimant's right to challenge the employer's denial and was sufficient to warrant an assessed fee under ORS 656.386(1)).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's pre-hearing services concerning the rescission of Kemper's compensability denial is $500, to be paid by Kemper. In reaching this conclusion, we have particularly considered 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.[2]

Claimant also requests a fee on Board review. Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, ORS 656.295(6), compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod on recon 119 Or App 447 (1993). Alexsis' appeal to the Board placed claimant's award at risk. Claimant's attorney was justified in actively participating at the Board proceeding to protect claimant's interests. Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review, payable by Alexsis. ORS 656.382(2). See International Paper Co. v. Riggs, 114 Or App 203 (1992).

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[1] In her brief, claimant also requests an attorney fee for establishing a medical services claim for which Kemper should be responsible. (Claimant's Respondent's Brief at 3). Kemper denied the compensability of claimant's CTS claim. It issued no medical services denial. Medical services was not raised at hearing. Consequently, we do not address the attorney fee request based on the medical services issue.

[2] We note that claimant was represented by an attorney at hearing, but retained a different attorney on review. Nevertheless, Kemper and Alexsis are each required to pay its entire award to claimant's appellate counsel, claimant's current attorney of record. Thereafter, the manner in which the fee is shared by claimant's current and former counsel is a matter to be decided between the two of them, not this forum. Timothy S. Waggoner, 43 Van Natta 1856 (1991); Fred L. Snider, 43 Van Natta 577 (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 review is $1,500, to be paid by Alexsis. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee award for services related to securing her attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated June 8, 1994 is modified in part and affirmed in part. For pre-hearing services regarding the compensability issue, claimant's attorney is awarded $500, to be paid by Kemper. The Referee's order is otherwise affirmed. Claimant's attorney is also awarded $1,500 for services on Board review, to be paid by Alexsis.

In the Matter of the Compensation of
JAMES A. EDWARDS, JR., Claimant
WCB Case Nos. 93-05533 & 93-03734
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld Laidlaw Transit/Crawford & Company's (Crawford) denial of claimant's aggravation claim for a herniated disc condition; and (2) upheld Pac-West Glass/NAICC's (NAICC) denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following substitution for the first sentence of the fifth full paragraph on page 3: Claimant's herniated disc is not compensably related to his September 16, 1991 lumbar strain with Crawford.

CONCLUSIONS OF LAW AND OPINION

Claimant experienced a compensable low back injury with pain into his left leg to the knee on September 16, 1991, which was diagnosed as an acute low back strain with nerve root impingement. (Exs. 4 and 6). Crawford closed his claim on December 6, 1991 with no permanent disability award.

Although claimant experienced low back pain several times a week, he sought no medical treatment for his low back until October 2, 1992, when he treated conservatively with Dr. Freistat, osteopath, for low back pain on the right. On January 19, 1993, claimant returned to Dr. Freistat complaining of low back pain on the left that started two days earlier. He was again treated conservatively.

On or about February 1, 1993, claimant began working for NAICC's insured. His job consisted of driving and lifting. Claimant worked at this job for about two weeks. On February 26, 1993, claimant sought treatment for severe pain in his left buttock that radiated to the left posterior thigh and calf, with foot numbness. He was diagnosed with a herniated disc at L5-S1 on the left and early disc degeneration at L4-5.

Compensability - Aggravation of 1991 Injury

Because there was no showing that claimant's herniated disc was in existence at the time of the 1991 injury, and claimant did not exhibit any symptoms consistent with an extruded disc prior to February 26, 1993, the Referee concluded that claimant's herniated disc was unrelated to his September 16, 1991 lumbar strain and was therefore not a compensable aggravation of his 1991 injury. We affirm the Referee, but for different reasons.

In order to establish a compensable aggravation, claimant must prove that his compensable 1991 injury with Crawford's insured has worsened since the last award of compensation. See ORS 656.273(1). The parties do not dispute that claimant's herniated disc condition, if compensably related to the 1991 injury, is a worsened condition. The issue, therefore, is whether the herniated disc is compensably related to the 1991 injury.

As noted above, claimant's herniated disk arose more than a year after his original claim was closed. Claimant contends that the 1991 injury is a material contributing cause of his herniated disc, i.e., the herniated disc was directly caused by the industrial accident. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992) (The material contributing cause test applies to a condition or need for treatment that is directly caused by an industrial accident (primary consequence), whereas the major contributing cause test applies to a condition or need for treatment that is caused by a compensable injury (secondary consequence)). The major contributing cause test is not applied to conditions directly, though belatedly, related to the original compensable event. Id.

Both Dr. Berselli, claimant's attending neurosurgeon, and Dr. Holman, who treated claimant for the original injury, opined that it was only medically possible, rather than probable, that claimant's 1991 accident caused damage to the annulus fibrosus, which worsened and eventually ruptured. (See Exs. 38a-21, 24, 26, 27 and 41-25). Gormley v. SAIF, 52 Or App 1055 (1981) (To establish medical causation one needs to prove probability). Consequently, we conclude that claimant's herniated L5-S1 disc did not arise directly, though belatedly, from the 1991 industrial accident.

Given our conclusion that the herniated disc did not arise directly from the 1991 industrial accident, in order to establish compensability of his aggravation claim, claimant must prove that the 1991 injury is the major contributing cause of the herniated disc. See ORS 656.005(7)(a)(A). Both Drs. Berselli and Holman opined that, if the 1991 strain injury contributed to claimant's herniated disc, it was not the major contributing cause. (See Exs. 38a-27 and 40). Consequently, claimant has failed to carry his burden to prove that his herniated disc is a compensable consequence of his 1991 injury. Thus, his aggravation claim is not compensable.

Compensability - New Injury or Occupational Disease

Alternatively, claimant contends that he experienced either a new injury or occupational disease at NAICC's insured. We affirm the Referee's opinion on this issue with the following supplementation.

The Referee analyzed this claim as an occupational disease rather than an injury, on the basis that claimant did not experience a discrete injury while employed at NAICC's insured. The distinction between disease and injury does not turn on whether a claimant experiences a discrete injury, but on whether the onset of the condition occurs during a discrete period, i.e., is "sudden in onset," rather than gradual in onset over a long period of time. Valtinson v. SAIF, 56 Or App 184 (1982) (An injury is distinguished from a disease, in part, on whether it occurs during a discrete period rather than over a long period of time).

Claimant contends that he worked for NAICC's insured for a little over a week before he noticed pain and numbness in his leg that worsened substantially by the time he left his employment there at about February 22, 1993. Although claimant does not claim that he experienced an accident or discrete injury, he indicated that his symptoms came on during a discrete period of time. An onset of symptoms within a discrete period of time is supported by Dr. Berselli's opinion. In trying to pinpoint when the herniated disc occurred, he explained that claimant's numbness in his thigh, which claimant noticed on February 16, 1993, was consistent with a herniated disk, as were the left leg and hip symptoms that claimant reported as occurring two days prior to seeing Dr. Freistat on February 26, 1993.

(Exs. 13, 38a-18, -19, -21, -23). Moreover, Dr. Berselli indicated that "something happened in February" to cause claimant's disk condition. (Ex. 38a-21 and -24). Consequently, we conclude that claimant's condition developed within a discrete period. Therefore, we analyze claimant's herniated disk condition as an injury rather than an occupational disease.[1]

Dr. Berselli was unable to say that claimant's work activities at NAICC's insured, as opposed to other possible causes (the 1991 injury or a spontaneous rupture) caused claimant's herniated disk.[2] (Ex. 38a-21, -26, -30 and -31). Thus, we are not persuaded that work activities contributed to the condition. Accordingly, we conclude that claimant has failed to prove the compensability of his herniated disk. See ORS 656.005(7)(a).

ORDER

The Referee's order dated April 13, 1994 is affirmed.

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[1] Were we to have concluded that the herniated disc arose gradually over a long period of time, an occupational disease analysis would be appropriate. In that case, we would adopt the Referee's opinion with the exception of the second paragraph on page 3.

[2] Although at one point in his deposition Dr. Berselli indicated that the lifting at NAICC's insured could have caused an already damaged disk to extrude, and concluded that work activities at NAICC's insured were more than incidental but not the major cause of claimant's disk, we find his opinion unpersuasive to establish compensability. First, Dr. Berselli provided this opinion in response to Dr. Freistat's opinion that claimant had an injury prior to going to work for NAICC's insured, which is not reflective of Dr. Berselli's own opinion that "something" occurred in February 1993. (See Ex. 38a-21, -24 and 29). Moreover, Dr. Berselli's reasoning itself is speculative, and establishes no more than a possibility of a causal connection. See Gormley v. SAIF, supra. Claimant's burden of proof is not met unless he presents medical evidence affirmatively attributing his condition to work activities on the basis of medical probability, rather than possibility. See Miller v. SAIF, 60 Or App 557 (1982). Dr. Berselli's statement that claimant's work activities "could" have caused his already damaged disk to extrude is not sufficient.

Moreover, even if claimant experienced an "injury" for which he sought treatment prior to his employment at NAICC's insured, as Dr. Freistat opined, and the lifting at work combined with the preexisting condition, claimant has failed to carry his burden to prove that his injury at NAICC's insured was the major contributing cause of his combined condition. ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
RODGER L. GAINES, Claimant
WCB Case Nos. 93-09249, 93-07221 & 93-06228
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Roberts, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee McCullough's order that upheld Liberty Northwest Insurance Corporation/Harvey Cain Construction's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is whether the Referee erred in concluding that claimant's symptomatic worsening of his accepted low back condition was more than a waxing of symptoms contemplated by a

November 1992 Order on Reconsideration. Claimant asserts that the Order on Reconsideration did not contemplate future waxing and waning of his low back symptoms. We agree.[1]

To establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in decreased earning capacity. Smith v. SAIF, 302 Or 396, 401 (1986). Because claimant received a previous permanent disability award for his condition, he 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). 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. See Lucas v. Clark, 106 Or App 687, 691, rev den 312 Or 150 (1991).

Here, the Referee concluded that, based on an October 1992 report by Dr. Burr, the medical arbiter, the November 1992 Order on Reconsideration predicted future flare-ups of claimant's low back condition. Burr diagnosed residual radiculopathy, herniated nucleus pulposus, right L5-S1. (Ex. 26-4). Burr also stated that, based on objective findings, claimant had a chronic and permanent condition arising from his accepted lumbosacral strain. (Id). Furthermore, he concluded that claimant's residual functional capacity was light to medium, and recommended that claimant avoid repeated bending; that lifting and carrying continuously was permissible, with a 35-pound limitation; that occasional lifting of 50 pounds be allowed, with correct body mechanics; however, Dr. Burr recommended that claimant avoid any lifting with back flexion. (Id).

We find that the restrictions recommended by Dr. Burr related to claimant's impairment, and did not constitute a prediction that claimant's symptoms would flare if he engaged in restricted activity. Judy A. Jacobson, 46 Van Natta 2459 (1994). In other words, we find that claimant's restrictions provided evidence of his ability to perform or not perform certain activities without necessarily commenting on whether claimant's symptoms would fluctuate. Id at 2459.

This case is distinguishable from Patricia J. Sampson, 45 Van Natta 771, aff'd mem Sampson v. Shriners Hospital et al., 125 Or App 338 (1993). There, the claimant, a surgical nurse, filed an aggravation claim relating to an allergic reaction to gloves she used at work. At the time of a prior Determination Order, Dr. Foggia had concluded that the claimant was

> "unable to return to working as a surgical nurse * * * [and] unable to participate in any hospital ward nursing type endeavors in view of the fact that she would not be able to carry out her absolute functions as a nurse on the ward relative to the many encounters they have with using gloves, et cetera. Therefore, [claimant] will probably not be able to return to hospital type employment[.]" Id. at 772 (brackets in original).

Foggia described the claimant's condition as chronic, and stated that she would be unable to come in contact with any trauma, degree of chemical irritation or any friction of any consequence on a daily basis. Id. Based on that evidence, the Board concluded that Foggia's opinion regarding the claimant's permanent disability included a prediction of future problems associated with exposure, of the type and degree that the claimant experienced when she attempted to return to work requiring use of gloves. Id.

Here, in contrast, Dr. Burr merely recommends some limitations on claimant's activities; he does not state, either expressly or implicitly, that claimant will experience any particular symptoms should he exceed the proposed limitations. On that ground, we find Sampson inapposite.

Liberty argues that, because claimant had fluctuating low back symptoms before the Order on Reconsideration issued, the Order necessarily contemplated future waxing and waning of the low back condition. We disagree. Dana J. Fisher, 45 Van Natta 225 (1993) (history of exacerbations not sufficient to establish that permanent disability award contemplated future waxing and waning of symptoms).

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[1] Claimant also argues that, because the disability standards do not rate "waxing and waning" of symptoms, the Workers' Compensation Division was without authority to compensate claimant for any waxing and waning of his low back symptoms by the Order on Reconsideration. In light of our conclusion, we need not address that argument.

In sum, we find no contemporaneous medical report establishing that the November 1992 Order on Reconsideration contemplated future waxing and waning of claimant's low back symptoms. Consequently, it is unnecessary to determine whether claimant's current symptoms exceeded any contemplated fluctuating symptoms. See ORS 656.273(8); Daniel C. Reddekopp, 46 Van Natta 1536 (1994).

The parties do not dispute that claimant's aggravation claim is otherwise compensable. Accordingly, we reverse the Referee decision upholding Liberty/Harvey Cain Construction's denial of that claim.

Claimant's counsel is entitled to an attorney fee for services at hearing and on review concerning 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 $3,500, payable by Liberty Northwest Insurance Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated March 7, 1994 is reversed in part and affirmed in part. Liberty Northwest Insurance Corporation's aggravation denial on behalf of Harvey Cain Construction is set aside and the claim is remanded to Liberty for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded $3,500, to be paid by Liberty. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LELA M. KENFIELD, Claimant
WCB Case No. 91-08331
ORDER ON REMAND
Darris K. Rowell, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

This matter is on remand from the Court of Appeals. Our prior order affirmed and adopted the Referee's order that dismissed claimant's request for hearing based on lack of jurisdiction. Lela M. Kenfield, 45 Van Natta 1479 (1993). Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted low back strain. A 1987 Determination Order closed the claim. In October 1990, Dr. Grant began treating claimant for chronic myofascial low back and left leg pain and chronic myofascial left neck, shoulder and arm pain. He also prescribed physical therapy. The employer denied payment of medical treatment by Dr. Grant, as well as physical therapy, on the basis that it constituted noncompensable palliative medical treatment. See ORS 656.245. Claimant requested a hearing.

Finding that the sole issue was whether the disputed medical treatment was palliative or curative, the Referee concluded that the Hearings Division did not have original jurisdiction over claimant's request for hearing. In so holding, the Referee relied on the Board's orders in Stanley Meyers, 43 Van Natta 2643 (1991), and Gladys M. Theodore, 44 Van Natta 905 (1992). On review, the Board affirmed and adopted the Referee's order, additionally noting that it did not have authority to address claimant's contention regarding the unconstitutionality of ORS 656.245. Lela M. Kenfield, supra. The Court of Appeals reversed and remanded for reconsideration in light of its decision in Meyers v. Darigold, Inc., supra.

ORS 656.327(1)(a) provides for review by the Director of a dispute over medical treatment that is alleged to be "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services." In Stanley Meyers, supra, the Board had held that Director review under ORS 656.327(1)(a) was mandatory and, therefore, the Director had original jurisdiction of medical treatment disputes falling under the statute. In Gladys M. Theodore, supra, the Board found that a dispute over whether medical treatment was palliative or curative concerned the effectiveness and appropriateness of such medical services and, applying Meyers, held that the Director also had original jurisdiction of such matters.

The Court of Appeals first reversed our order in Meyers, determining that the Director acquired exclusive jurisdiction over a medical treatment dispute only with a "wish" for review by the proper party. Meyers v. Darigold, Inc., supra, 123 Or App at 221-22. According to the court, if no "wish" for review was filed, jurisdiction remained with the Board. Id.

The court also reversed the order in Gladys M. Theodore, supra. Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993). The court agreed with the Board that a dispute concerning whether medical treatment was palliative or curative could fall within the Director's review authority under ORS 656.327. Id at 176. However, pursuant to Meyers, the court further found that, if no party "wished" Director review, the Hearings Division and the Board had jurisdiction over the matter. Id.

Here, no party in this case has "wished" for Director review under ORS 656.327(1). Therefore, we have jurisdiction regarding the medical services dispute. Meyers v. Darigold, Inc., supra; Theodore v. Safeway Stores, Inc., supra. Inasmuch as claimant is medically stationary, we next consider whether the disputed treatment is palliative or curative. See ORS 656.245(1)(b).

Claimant was first evaluated by Dr. Grant in August 1990 at the employer's request. Dr. Grant in part diagnosed chronic post-traumatic myofascial pain syndrome of the low back and left lower extremity and chronic post-traumatic myofascial pain syndrome of the left neck, shoulder and upper extremity. (Ex. 53-4). Dr. Grant found that claimant was medically stationary and able to perform sedentary, light, and restricted medium work. (Id).

In October 1990, claimant returned to Dr. Grant for treatment. Dr. Grant provided the same diagnoses, noting that the conditions were "medically stationary though still symptomatic." (Ex. 56-2). Dr. Grant prescribed physical therapy and a home program of icing, stretching and heating. (Id).

Following two weeks of physical therapy, Dr. Grant noted that claimant was experiencing less pain and increased range of motion and function. (Ex. 58). Dr. Grant noted that claimant's conditions were "medically stationary" but "improving symptomatically" and continued to prescribe physical therapy. (Id). Dr. Grant provided similar findings during subsequent examinations. (Ex. 60-1, 62-1). Dr. Grant also indicated that claimant was capable of performing sedentary and light work. (Id).

Finally, Dr. Grant reported to claimant's attorney that "any and all of the physical therapy * * * was ordered in hopes that it would be more curative than anything else." (Ex. 63). However, he further stated:

> "In retrospect, I would have to say that the treatment was partially curative and partially palliative in nature. Undoubtedly the physical therapy decreased her objective findings, decreased her symptomatology, and increased her functional level. Unfortunately, it did not provide a full curative benefit, and she continues to have intermittent symptoms, which she is dealing with mainly on a home program basis." (Id).

Palliative care is a "medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable condition as compared to those medical services rendered to heal or permanently alleviate or eliminate an undesirable medical condition." OAR 436-10-005(29) (WCD Admin. Order 32-1990). We first note that we do not necessarily defer to Dr. Grant's description of the medical treatment as "partially curative" and "partially palliative" inasmuch as it is a legal opinion. Rather, we examine the entire medical record to determine whether the treatment was palliative or curative according to the applicable definition.

We find that the record in this case establishes that Dr. Grant's examinations and physical therapy constituted palliative care.[1] In particular, Dr. Grant at all times indicated that, although symptomatically improving, claimant's conditions were medically stationary. Dr. Grant also never modified his initial release to sedentary and light duty work. In light of claimant's improved symptomatology, we find that such evidence shows that Dr. Grant considered claimant's conditions to be stable throughout his treatment, and that treatment was rendered in order to reduce the symptoms of her stable condition rather than alleviate or eliminate the condition itself.

Under ORS 656.245(1)(b), palliative care rendered after the worker becomes medically stationary is not compensable "except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device." Inasmuch as claimant is not permanently and totally disabled, Dr. Grant did not prescribe medication, and claimant does not have a prosthetic device, we conclude that the palliative care is not compensable under ORS 656.245(1)(b). Consequently, the Director has exclusive jurisdiction of any further challenge to the employer's denial of the medical services. See Hathaway v. Health Future Enterprises, 125 Or App 549 (1993) (holding that the Director had exclusive jurisdiction of a denial of palliative care that was not the type compensable under ORS 656.245(1)(b)), aff'd 320 Or 383 (1994); Daniel K. Bevier, 46 Van Natta 41 (1994) (determining that, in order to decide if the Director had exclusive jurisdiction of a palliative care dispute, it was necessary to first address whether the medical services were compensable under ORS 656.245(1)(b)).

Finally, claimant asserts that a finding that the medical treatment is palliative deprives her of her rights guaranteed by the Fifth and Fourteenth Amendments of the United States Constitution because, prior to the enactment of ORS 656.245(1)(b), she had a "vested property interest in continued medical services" and the statute deprives her "of this valuable property right without due process or just compensation." In view of the procedure under ORS 656.245(1)(b) allowing for Director resolution of disputes concerning palliative treatment, we find that it has not yet been fully decided whether claimant has been "deprived" of medical services. Therefore, we find that it would be premature to address claimant's constitutional argument.

Accordingly, on reconsideration of our July 15, 1993 order, the Referee's order dated September 9, 1992 is reversed. Claimant's request for hearing is reinstated. The self-insured employer's denial is upheld.

IT IS SO ORDERED.

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[1] Claimant additionally asserts that treatment by Dr. Grant was "diagnostic in nature" and, therefore, not palliative. First, we find no authority for claimant's apparent understanding that diagnostic services as a category qualify as curative treatment. On remand from the court in Gladys M. Theodore, 46 Van Natta 318, 319 (1994), we explained that a physician's medical services were curative because, at minimum, they "were designed to diagnose claimant's condition for the purposes of evaluating the appropriate course of action to heal, permanently alleviate, or eliminate claimant's condition." This finding shows that diagnostic services can qualify as curative care under OAR 436-10-005(29); however, diagnostic services rendered to temporarily reduce or moderate the intensity of an otherwise stable condition would be palliative.

Moreover, we find no merit to claimant's assertion that Dr. Grant's services were diagnostic. Because Dr. Grant initially examined claimant at the employer's request, he had already diagnosed her conditions when claimant returned to him in October 1990. Furthermore, the record shows that his examinations after that date were to treat claimant's conditions rather than discover what they were.

In the Matter of the Compensation of
JERALD T. KILBY, Claimant
WCB Case Nos. 93-09502, 93-04650 & 93-04979
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys
Neil W. Jones, Defense Attorney
Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Safeco Insurance Company, on behalf of Quality Fence Co., requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's bilateral carpal tunnel syndrome (CTS); and (2) upheld the denials of the same condition issued by Bi-Mart, a self-insured employer, and the SAIF Corporation, on behalf of Quality Fence Co. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On April 30, 1990, claimant saw his family physician, Dr. Walters, concerning numbness and tingling in both hands. At that time, claimant worked for Bi-Mart. In October 1990, claimant began working at Quality Fence Co., which was insured by Safeco. As of December 31, 1992, SAIF provided coverage for Quality Fence.

On December 20, 1990, Dr. Maukonen, neurologist, examined claimant and diagnosed right carpal tunnel syndrome and thoracic outlet. He prescribed a splint for claimant's right hand. Claimant did not seek further treatment until January 1993, when he saw Dr. Worland, hand surgeon. Dr. Worland diagnosed bilateral carpal tunnel syndrome and performed a right carpal tunnel release in February 1993. As a result of the surgery, claimant did not work for a period of time.

Applying the last injurious exposure rule, the Referee found Safeco responsible for claimant's bilateral carpal tunnel syndrome. On review, Safeco asserts that responsibility properly is assigned to SAIF. Claimant agrees. According to SAIF, the Referee's assignment of responsibility to Safeco should be affirmed.

Inasmuch as claimant's carpal tunnel syndrome has previously not been accepted or otherwise determined to be compensable, we agree with the Referee and the parties that responsibility is determined pursuant to the last injurious exposure rule. See Gloria C. Garcia, 45 Van Natta 1702, 1703 n.1 (1993) (citing Fred A. Nutter, 44 Van Natta 854 (1992)). Under the last injurious exposure rule, the potentially causal employer at the time of disability is assigned initial liability for the disease. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not experience time loss due to the condition before seeking medical treatment, the date he first seeks medical treatment for the condition. Timm v. Maley, 125 Or App 396, 401 (1993). The dispositive date is the date claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

The Referee found that claimant first sought treatment for symptoms of his bilateral CTS in April 1990, when he saw Dr. Walters. We agree. (See Ex. 1; see also Ex. 23). Accordingly, responsibility is initially assigned to Bi-Mart.

In order to shift responsibility to Safeco, the later carrier, Bi-Mart must show that claimant's later employment with Safeco's insured (Quality Fence) actually contributed to a worsening of his compensable bilateral wrist conditions. Timm v. Maley, supra; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 or App 461, 465 (1988).

The undisputed medical evidence establishes that claimant's work at Quality Fence was the major contributing cause of claimant's bilateral CTS. (Exs. 15, 16, 18, 19). Accordingly, because claimant's work at Quality Fence actually contributed to a worsening of his CTS, responsibility shifts to Safeco, the first insurer on the risk during claimant's employment at Quality Fence. See Timm v. Maley, supra; Oregon Boiler Works v. Lott, supra; Spurlock v. International Paper Co., supra.

In order to shift responsibility to SAIF, the later carrier, Safeco must show that claimant's later employment actually contributed to a worsening of his compensable bilateral wrist conditions. Id. With regard to SAIF's period of coverage for Quality Fence, the medical evidence shows only that claimant's work activities while SAIF was on the risk (post-December 31, 1992) could have contributed to claimant's condition. (Exs. 12, 15, 16, 18, 19). Therefore, finding no evidence that work activities during SAIF's coverage actually contributed to a worsening of claimant's condition, we conclude that responsibility does not shift to SAIF. Accordingly, Safeco remains responsible for claimant's bilateral CTS condition.

Because compensability was at issue at hearing and the Referee's order addressed compensability, claimant's compensation remained at risk on review. See Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). Therefore, 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 $500, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 10, 1993, as reconsidered April 5, 1994, and amended April 19, 1994, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, to be paid by Safeco.

December 21, 1994 Cite as 46 Van Natta 2488 (1994)

In the Matter of the Compensation of
WILLIAM J. KNIGHT, Claimant
WCB Case No. 92-14729
ORDER ON REVIEW
Kevin L. Mannix, P.C., Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Referee Mongrain's order which declined to set aside a Disputed Claim Settlement (DCS). With his brief, claimant submits additional documents. On review, the issues are remand and the validity of the DCS.

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

Claimant submitted several additional documents with his brief. We may only review the record presented at hearing. Therefore, we regard these submissions as a motion for remand to the Referee. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must 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).

The additional documents consist of the following: (1) a list of temporary disability compensation payments made from July 31, 1987 through December 1, 1989; (2) a list of medical record references from 1987, 1988, 1989, and 1990; (3) an October 1, 1987 report from Dr. Dunn II, M.D.; (4) a September 22, 1988 chart note from Dr. O'Connell, Ph.D.; (5) an April 11, 1989 report from Dr. Ewald, M.D.; and (6) a September 28, 1991 hospital discharge summary from Dr. Campagna, M.D.

The hearing was held on December 16, 1993 and January 19, 1994. All of the additional documents claimant submits were obtainable with due diligence at the time of the hearing. Furthermore, we do not find the improperly, incompletely or otherwise insufficiently developed. Therefore, we deny the motion for remand.

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Roberts v. Willamette Industries, 82 Or App 188 (1986); Pruitt Watson, 45 Van Natta 1633 (1993). In other words, a bona fide dispute as to compensability is a prerequisite to a valid DCS. See Pruitt Watson, supra (where claim acceptance was invalidly revoked by an improper back up denial, there was no bona fide dispute concerning compensability to be resolved; therefore, the DCS was set aside).

Here, there is no contention that there was no bona fide dispute as to compensability. In any event, the record would not support such a contention. The employer had issued partial denials of claimant's psychological treatment and current conditions, and claimant disputed those denials. These partial denials and claimant's contention that the treatment and conditions denied were compensable constituted a bona fide dispute as to compensability. Thus, the prerequisite to a valid DCS provided by ORS 656.289(4) was met.

The other avenue for setting aside a DCS is provided by Mary Lou Claypool, 34 Van Natta 943 (1982). In Claypool, the Board concluded that, whether viewed as an agency order or a contract, the grounds for setting aside a DCS were substantially the same, that is, mistake, inadvertence, surprise, excusable neglect, fraud, misrepresentation or other misconduct of an adverse party. Id. at 34 Van Natta 946.

We agree with the Referee's analysis of this avenue of attack on the DCS. Claimant has proven none of the above factors that would justify setting aside the DCS. Claimant was mentally competent to enter into the DCS and was advised by his attorney of the consequences of the settlement. (Ex. 29, #2 Tr. 12-43); see also Jane B. Parvis, 41 Van Natta 2037 (1989).

Finally, if claimant has a dispute with the representation provided by his former attorney, that dispute is not subject to our authority.

ORDER

The Referee's order dated March 9, 1994 is affirmed.

In the Matter of the Compensation of
MICHAEL R. LAMBERTSEN, Claimant
WCB Case No. 94-04538
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Galton's order which awarded claimant temporary partial disability from February 27, 1993 through March 16, 1993. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

On December 29, 1992, claimant, a mechanic, sustained a compensable contusion to the scalp and a thoracic strain. On January 4, 1993, Dr. Peden released claimant to regular work without restrictions effective January 8, 1993. (Ex. 29). Claimant testified that he returned to "somewhat modified" work. (Tr. 23). The employer testified that he made no conscious effort to restrict claimant's work and that claimant never told him that he was having a problem doing his work. (Trs. 37, 38).

On February 26, 1993, claimant's employment was terminated because he was not keeping up with his workload. On March 17, 1993, claimant consulted an orthopedist, Dr. Dahlin. Dr. Dahlin diagnosed a back contusion with a T-8 compression fracture, for which he recommended physical therapy. On January 19, 1994, Dr. Dahlin stated: "As far as my records indicate the patient can be considered completely disabled through March 31, 1993." (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought temporary disability benefits from February 27, 1993 through March 16, 1993. The Referee concluded that claimant was temporarily disabled from engaging in regular employment duties during the disputed period and was thus entitled to the award of temporary disability as requested.

On review, SAIF contends that Dr. Dahlin's authorization of temporary disability cannot reasonably be interpreted to establish claimant's entitlement to temporary disability prior to March 17, 1993, the date Dr. Dahlin first examined claimant. We agree.

Claimant has the burden of proving by a preponderance of the evidence that he was entitled to temporary disability for the period in question. See ORS 656.266. We perceive the issue on review as whether Dr. Dahlin's statement that claimant was disabled through March 31, 1993 can establish that claimant was totally disabled for the period of February 27, 1993 through March 16, 1993.

We agree with SAIF that the most reasonable inference to be drawn from Dr. Dahlin's statement is that claimant was disabled from the date of first treatment on March 17, 1993 through March 31, 1993. Dr. Dahlin had no personal knowledge of claimant's condition prior to his first treatment, nor is it clear what, if any, medical records Dr. Dahlin possessed regarding claimant's medical treatment prior to March 17, 1993. Such information would be particularly important where, as here, another physician (Dr. Peden) had previously released claimant to return to work without restriction as of January 8, 1993.

At best, Dr. Dahlin's authorization of temporary disability is ambiguous. Inasmuch as it is claimant's burden of proof, we are unable to conclude on the basis of this record that claimant has established entitlement to temporary disability for the period from February 27, 1993 through March 16, 1993. Accordingly, we reverse the Referee's decision on this issue.

ORDER

The Referee's order dated July 19, 1994 is reversed.

In the Matter of the Compensation of
DANIEL P. MOORE, Claimant
Own Motion No. 94-0302M
OWN MOTION ORDER ON RECONSIDERATION
Andrew H. Josephson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 2, 1994 Own Motion Order in which the Board reopened his claim for the payment of temporary disability benefits beginning the date he is hospitalized for the proposed surgery. With his request for reconsideration, claimant submitted additional information regarding a prior hospitalization, from which time he requests temporary disability compensation be paid.

In our prior order, we authorized reopening of claimant's claim beginning the date he is hospitalized for the proposed foraminotomy at L4-5 and fusion from L4 to S1. The record submitted by SAIF contained a recommendation from Dr. Nash that claimant be hospitalized for "a program of intensive care with possible surgical intervention." The record also contained a May 6, 1994 admittance physical and history work-up by Dr. Nash. However, the record did not contain hospital records or a

discharge summary. If claimant had been admitted for emergency treatment and discharged the same day, that treatment without a hospital overnight "stay" would not constitute hospitalization. Fred E. Smith, 42 Van Natta 1538 (1990). Additionally, claimant's attorney stated in a June 21, 1994 letter that "[i]n May [claimant] was hospitalized due to his compensable back condition. However, inasmuch as the "hospitalization" issue was not substantiated with evidence, the Board was only authorized to award temporary disability compensation beginning the date of claimant's proposed surgery.

With his request for reconsideration, claimant submitted hospital records which reflect treatment commencing May 6 and ending May 9, 1994. Claimant also submitted a discharge summary, which reflects that claimant was hospitalized on May 6, 1994 and discharged on May 9, 1994. Since claimant has now submitted evidence which satisfies the "hospitalization" requirement, we amend our order to authorize temporary disability compensation beginning May 6, 1994, the date claimant was hospitalized for treatment.

Accordingly, our December 2, 1994 order is withdrawn. On reconsideration, as amended herein, we adhere to and republish our December 2, 1994 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

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

IT IS SO ORDERED.

December 21, 1994 Cite as 46 Van Natta 2491 (1994)

In the Matter of the Compensation of
DENNIS E. SINOR, Claimant
Own Motion No. 94-0524M
OWN MOTION ORDER
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

On August 23, 1994, the self-insured employer submitted claimant's request for temporary disability compensation for his compensable April 26, 1989 cervical injury. The employer recommended against reopening the claim on the basis that claimant's compensable cervical condition does not require surgery or hospitalization. In response, claimant contended that his aggravation rights had not expired. Therefore, claimant contended, the Board did not have own motion jurisdiction over his claim. Instead, claimant argued, his claim should be processed as an aggravation claim pursuant to ORS 656.273.

Subsequent to these representations, the parties entered into a Claims Disposition Agreement (CDA), which was approved by the Board on December 14, 1994. Regarding the April 26, 1989 cervical injury claim, the parties agreed that, in consideration for a lump sum payment of $3,000, "claimant shall release all present and future rights to temporary disability benefits, permanent disability benefits, vocational rehabilitation benefits, survivors benefits, and all other workers' compensation benefits that may have otherwise accrued to the claimant or his survivors . . . except the claimant's entitlement to medical services[.]"

A claim for additional compensation made outside the time limits of ORS 656.273 falls within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Edward R. Reuter, 42 Van Natta 19 (1990). Under our own motion authority, we may authorize 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. Thus, own motion relief is limited to temporary disability benefits.

However, given the fact that claimant has released his right to temporary disability benefits, among other benefits, regarding the April 26, 1989 cervical injury, the issue is moot as to whether this claim should be processed as an aggravation under ORS 656.273 or an own motion claim under ORS 656.278. In other words, whether the claim is processed as an aggravation claim or an own motion claim, claimant is not entitled to the relief he seeks. Therefore, even assuming that the claim is within the Board's own motion jurisdiction, claimant is not entitled to any own motion relief (temporary disability benefits) pursuant to the CDA.

Accordingly, claimant's request for own motion relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEAN V. HENNESSY, Claimant
WCB Case No. 93-13739
ORDER ON REVIEW (REMANDING)
Lundeen, et al., Defense Attorneys
Willner & Heiling, Attorneys

Reviewed by Board Members Neidig and Gunn.

Dr. Belhumeur, claimant's medical services provider requests review of Referee Hoguet's order that affirmed a Director's order under ORS 656.327(2) finding that claimant's April 23, 1991, May 7, 1991 and July 3, 1991 videofluoroscopy (VF) examinations were inappropriate.[1] Dr. Belhumeur contends that the Referee erred in limiting his consideration of the evidence to the record before the medical director and requests that the Board consider the excluded evidence, or, alternatively, remand the case to the Referee for the same purpose.[2] The insurer contends that Dr. Belhumeur lacks standing to request Board review. On review, the issues are standing, remand, and, alternatively, review of a Director's order in a medical treatment dispute. We conclude that the medical provider has standing to request Board review and remand.

FINDINGS OF FACT

On July 17, 1991, the insurer petitioned the Director for relief from paying for VF evaluations by Dr. Belhumeur on the basis that they were unnecessary. On October 21, 1993, the Director issued an order finding that the use of VF was not appropriate and ordering the insurer not to reimburse Dr. Belhumeur. Dr. Belhumeur appealed the order to the Hearings Division. The referee set aside the Director's order, permitting the parties to request the Director to reopen the case in order to consider the Oregon Board of Chiropractic Examiners protocol (Oregon Protocol) for the use of VF. Dr. Belhumeur requested Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Standing

Before we proceed to the merits of this claim, we determine whether the medical provider has standing to request Board review. We have previously concluded that he does. See Ruby L. Goodman,

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[1] Although the Director's order purported to address only the appropriateness of the VF examinations billed on April 23, 1991 and May 7, 1991, as the VF examination of July 3, 1991 was not ordered by the worker's attending physician (Ex. 53-1), the order language included reimbursement for all three dates (Ex. 53-4).

[2] The medical service provider also requested that we remand to the Director. (Appellant's Brief at 6). We have authority to remand to the Director in those instances where the Director has failed to adopt a temporary rule or "stay" proceedings pursuant to ORS 656.726(3)(f)(C). Gallino v. Courtesy Pontiac-Buick-GMC, 134 Or App 538 (1993). That is not the issue in this case.

46 Van Natta 810 (1994)[3] (Medical service providers in medical services dispute have the same appeal rights as any other "party," which includes the right to Board review of a referee's order).

Evidence

The second issue is whether the Referee was limited to considering the evidence of the record before the medical director. In Julie Sturtevant, 45 Van Natta 2344 (1993),[4] 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. Id. at 2347. Thus, based on Sturtevant, the Referee in this case was not limited to the record developed before the Director and could admit Exhibit 59 and the medical provider's testimony into evidence.[4] See also Ruby L. Goodman, 46 Van Natta at 810, n.3.

Remand

Claimant contends that this case should be decided on the basis of the record developed at hearing, which includes Exhibit 59 and the medical provider's testimony, or, in the alternative, that this case should be remanded to the Referee. We agree that remand is appropriate.

Because the Referee's review authority was not limited to the record developed before the Director, 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. Sturtevant, supra.

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, 45 Van Natta 2305 (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. Under the 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; Lois J. Schoch, supra. See also Ruby L. Goodman, supra.

Accordingly, we vacate the Referee's order and remand this matter to Referee Hoguet for further proceedings consistent with this order. At the further proceedings, the parties may present evidence regarding the propriety of Dr. Belhumeur's use of VF. See Lois J. Schoch, supra; see also Ronald J. Lombard, 46 Van Natta 49 (1994).

ORDER

The Referee's order dated April 4, 1994 is vacated. This matter is remanded to Referee Hoguet for further action consistent with this order. The Referee may conduct these further proceedings in whatever manner the Referee determines will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

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[3] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Goodman, supra, Chair Neidig directs the parties to her dissenting opinion in that decision.

[4] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Sturtevant, supra, Chair Neidig directs the parties to her dissenting opinion in that decision.

In the Matter of the Compensation of
GEORGE L. O'BRYAN, Claimant
WCB Case No. 94-02748
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Crumme's order which set aside its partial denial of claimant's right index finger condition. On review, the issue is compensability.

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

The Referee found, and we agree, that claimant's work injury combined with his preexisting tumor to cause or prolong his disability and need for medical services. Therefore, this claim is properly analyzed under ORS 656.005(7)(a)(B).

The Referee further found, and we agree, that the preponderance of evidence establishes that claimant's work injury, resulting in a fracture of the right index finger, was the major contributing cause of his resultant disability and need for medical treatment.

In so finding, we rely on the opinion of Dr. Long, claimant's attending physician. We find Dr. Long's opinion to be well-reasoned and based on a complete and accurate history of claimant's condition. Furthermore, Dr. Long performed claimant's finger surgery. Therefore, he is in the best position to evaluate the relative causal contributions to claimant's resultant condition. Accordingly, we give his opinion greater weight.

Dr. Long opined that claimant sustained a significant traumatic injury to his finger, which was the major contributing cause of a dramatic change in claimant's underlying condition. Dr. Long noted that claimant's tumor was asymptomatic prior to his work injury. Thus, Dr. Long concluded that claimant probably did not have a spontaneous fracture. After the work injury, and as a result of that trauma, Dr. Long determined that the preexisting tumor became more aggressive, necessitating surgery of claimant's finger. (See Exs. 34, 50, 51).

Under such circumstances, we find that claimant's work injury combined with his preexisting tumor, and the work injury was the major contributing cause of claimant's disability and need for medical treatment. ORS 656.005(7)(a)(B); see also U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

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

ORDER

The Referee's order dated June 22, 1994 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
DALE S. WEITMAN, Claimant
WCB Case Nos. 94-01114, 93-07410 & 93-03162
ORDER DENYING MOTION TO DISMISS
W. Todd Westmoreland, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney
Meyers, Radler, et al., Defense Attorneys

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS OF FACT

The Referee's order issued on October 24, 1994. Parties to that order were claimant, SAIF, Crawford & Company, and their respective insureds.

On November 18, 1994, SAIF mailed a request for Board review. The request did not include an acknowledgment of service or a certificate of personal service by mail upon claimant, Delta Air Lines/Crawford & Company, or Willamina Lumber Company (insured by SAIF). See OAR 438-05-046(2)(b); 438-11-005(3). However, the request did include such a certificate indicating that a copy of the request had been mailed to claimant's attorney and Delta/Crawford's attorney.

On November 23, 1994, the Board mailed a computer-generated letter to all parties acknowledging the request.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, SAIF's certificate of personal service by mail upon claimant's and Delta/Crawford's attorneys is uncontested. Furthermore, no contention has been made that either claimant or Delta/Crawford have been prejudiced by not directly receiving a copy of SAIF's request for review. In the absence of such a finding, we hold that SAIF's timely service by mail upon claimant's and Delta/Crawford's attorneys is adequate compliance with ORS 656.295(2). Franklin Jefferson, 42 Van Natta 509 (1990); Denise M. Bowman, 40 Van Natta 363 (1988). Under such circumstances, the Board has jurisdiction to consider SAIF's request for review. Argonaut Insurance Co. v. King, supra; Denise M. Bowman, supra.

Accordingly, claimant's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
VICTORIA J. WILLIAMS, Claimant
WCB Case No. 93-12775 & 93-02545
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Miller, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Referee Brazeau's order which: (1) declined to award temporary disability benefits between February 2, 1993 and June 4, 1993; and (2) declined to award penalties and attorney fees regarding an alleged "de facto" denial. The self-insured employer cross-requests review of that portion of the Referee's order which affirmed the October 8, 1993 Order on Reconsideration. Specifically, the employer requests that the Referee's order "affirming" the Order on Reconsideration be modified to reflect that temporary disability benefits were not due between February 2, 1993 and June 4, 1993. On review, the issues are entitlement to temporary disability benefits and penalties and attorney fees. We modify in part, affirm in part, and reverse in part.

FINDINGS OF FACT

Claimant compensably injured her left knee on September 6, 1990. In October 1990, claimant underwent an arthroscopic exploration of her left knee, which resulted in a partial medial meniscectomy. Dr. Lawton, treating physician, released claimant to regular work, and claimant returned to work, in November 1990.

On January 28, 1991, Dr. Lawton indicated that claimant was no longer medically stationary and was released only for modified work. In August 1991, the Orthopaedic Consultants examined claimant and recommended additional surgery for an anterior cruciate ligament reconstruction.

In September 1991, claimant returned to work, but then resigned on October 31, 1991 for maternity leave. Claimant again returned to work on February 1, 1992, but quit her job on May 1, 1992.

Claimant's claim was closed by a Determination Order on May 11, 1992, which awarded 19 percent scheduled permanent disability for the left knee. Claimant returned to work for the employer for one month in August 1992, and then resigned once again.

On October 30, 1992, Dr. Lawton recommended further arthroscopic evaluation. In November 1992, claimant was evaluated by Dr. Neuberg. Dr. Neuberg indicated that claimant was continuing in school, but would need to take a term off for surgery. (Ex. 46).

On February 3, 1993, claimant underwent another knee surgery. She did not look for work between February 3, 1993 and June 4, 1993. The employer reopened claimant's claim for surgery, but did not resume payment of temporary disability benefits. The employer paid all compensation related to claimant's knee conditions from the time of her original injury up through February 2, 1993.

On February 2, 1993, the employer completed a 1502 form indicating that it was accepting an aggravation of claimant's left knee injury. Claimant signed an attorney retainer agreement on March 1, 1993. Claimant's attorney requested a hearing on a "de facto" denial of claimant's knee conditions on March 19, 1993. The employer mailed the 1502 form to claimant on April 16, 1993. In a letter accompanying that form, the employer listed the accepted conditions as "left knee, meniscal tear and rupture of the anterior cruciate ligament." (Emphasis supplied).

Claimant was medically stationary and released for regular work on June 4, 1993. A June 30, 1993 Determination Order awarded additional permanent disability and temporary disability. The employer did not pay those awards. On October 8, 1993, an Order on Reconsideration affirmed the Determination Order in its entirety.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

Claimant contends that she is entitled to temporary disability benefits between February 3, 1993 and June 4, 1993. The Referee concluded that claimant was not in the workforce at the time of her February 3, 1993 disability, and was not entitled to temporary disability benefits.

We adopt and affirm the Referee's order with regard to this issue with the following supplementation.

The Referee's order "affirmed" the October 8, 1993 Order on Reconsideration. Yet, the Order on Reconsideration affirmed the June 30, 1993 Determination Order which had awarded temporary disability benefits from February 2, 1993 to June 4, 1993. Because we have affirmed the Referee's conclusion that claimant is not entitled to temporary disability benefits from February 2, 1993 to June 4, 1993, we modify the Referee's order and Order on Reconsideration to so indicate.

Penalties and Attorney Fee

The Referee concluded that the employer had "de facto" denied claimant's meniscus condition and her anterior cruciate ligament condition because the employer had not accepted or denied the conditions within 90 days of being advised of the conditions. However, because the employer had paid all compensation to which claimant was entitled, the Referee concluded that there were no amounts due upon which to base a penalty under ORS 656.262(10), and that there was no unreasonable resistance to the payment of compensation to warrant an attorney fee under ORS 656.382(1). We agree and adopt the Referee's reasoning concerning those issues.

Claimant contends that she is entitled to an attorney fee under ORS 656.386(1). Specifically, claimant argues that the employer did not accept her claim for a left meniscus tear and cruciate ligament tear until after her hearing request and, thus, her counsel was instrumental in obtaining compensation without a hearing. In response, the employer contends that it accepted claimant's aggravation claim on February 22, 1993, before claimant hired her attorney. (See Ex. 55). We agree with the employer's contention insofar as it pertains to the acceptance of the aggravation claim. However, we disagree with the employer's reasoning with regard to the acceptance of claimant's left knee meniscal tear and rupture of the anterior cruciate ligament conditions.

Whether an acceptance occurs is an issue of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. Gene C. Dalton, 43 Van Natta 1191 (1991); see Jannette I. Shue, 42 Van Natta 1750 (1990); Nancy V. Storey, 41 Van Natta 1951 (1989). Formal notice occurs after acceptance has been accomplished. "The question of whether notice has been properly furnished is one of claims processing, not a question of whether or not a claim has been accepted." Nancy V. Storey, supra at 1953; see Gene C. Dalton, supra at 1194.

Here, on February 2, 1993, the employer completed a 1502 form by checking the items which indicate that it had accepted a disabling aggravation of claimant's left knee strain injury claim. (Ex. 55). Thus, we find that acceptance of claimant's aggravation claim for a left knee strain had been accomplished on February 2, 1993. Since claimant did not retain counsel until March 1, 1993, and a hearing was not requested until March 19, 1993, we conclude that claimant is not entitled to an attorney fee under ORS 656.386(1) for services regarding the employer's acceptance of the aggravation claim.

Nevertheless, we find that claimant is entitled to an attorney fee pursuant to ORS 656.386(1) for her attorney's services in obtaining the employer's acceptance of her meniscal tear and ruptured anterior cruciate ligament conditions.

The employer originally accepted a "left knee strain." (Ex. 7). On October 22, 1990, claimant underwent surgery for a partial medial meniscectomy. (Ex. 18). On August 21, 1991, claimant was examined by a panel from the Orthopaedic Consultants. The panel recommended additional surgery for an anterior cruciate ligament reconstruction. On February 3, 1993, claimant underwent an anterior cruciate reconstruction. Her claim was reopened as a result of the surgery.

Although the employer paid all compensation related to claimant's meniscus and cruciate ligament conditions, it did not accept those conditions until after claimant requested a hearing on March 19, 1993 for a "de facto" denial of a medial meniscus tear and ruptured anterior cruciate ligament.

When a claimant's attorney is instrumental in obtaining rescission of a "de facto" denial shortly before or at a hearing, claimant is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1). See Nancy S. Jenks, 46 Van Natta 1441 (1994); Barbara J. Fuller, 46 Van Natta 1129 (1994); Wesley R. Craddock, 46 Van Natta 713 (1994). Likewise, in this case, claimant's attorney filed a request for hearing that resulted in the rescission of the insurer's "de facto" denial of the conditions listed in the employer's April 16, 1993 letter. Accordingly, claimant is entitled to an assessed attorney fee under ORS 656.386(1). Nancy S. Jenks, supra; Barbara J. Fuller, 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 in obtaining the rescission of the employer's "de facto" denial of claimant's left knee meniscus tear and anterior cruciate ligament rupture 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 the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, claimant is not entitled to an attorney fee for services devoted to securing her attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated January 5, 1994 is modified in part, affirmed in part, and reversed in part. The October 8, 1993 Order on Reconsideration is modified in that claimant is not entitled to temporary disability benefits between February 2, 1993 and June 4, 1993. For pre-hearing services in obtaining acceptance of claimant's meniscus tear and anterior cruciate ligament rupture, claimant's attorney is awarded an assessed attorney fee of $500, payable by the self-insured employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
GEORGE J. MAY, Claimant
WCB Case No. 93-11838
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Podnar's order that affirmed a Determination Order which classified his claim as nondisabling. In its brief, the SAIF Corporation argues that the Referee lacked jurisdiction since claimant did not request reconsideration of the Determination Order prior to requesting a hearing. On review, the issues are jurisdiction and classification. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation. Claimant sustained a compensable chest wall muscle strain on June 11, 1993. (Exs. 1, 3, 7).

Claimant continued working for the at-injury employer until August 18, 1993, when he quit because he felt that the employer was not protecting him from further injury by failing to recognize the physician-imposed work restriction against all lifting. (Exs. 2A, 7-1).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

SAIF contends that the Referee lacked jurisdiction over this matter since claimant did not request reconsideration of the October 23, 1993 Determination Order prior to requesting a hearing. We disagree.

SAIF accepted claimant's claim as nondisabling for a chest wall strain. Claimant requested review by the Department of SAIF's nondisabling classification. On October 23, 1993, a Determination Order issued which ordered that the claim remain classified as nondisabling.

In support of its argument that the Referee lacked jurisdiction to address the reclassification issue, SAIF relies on OAR 436-30-045(7). That rule provides:

> "(7) Pursuant to ORS 656.277, claims for nondisabling injuries will be processed by the Department in the same manner as claims for disabling injuries and if either party objects to the determination of Evaluation as to the worker's disabling/nondisabling status, that party must request a reconsideration by the Appellate Unit in accordance with ORS 656.268 before requesting a hearing under ORS 656.283."

In Walter T. Driscoll, 45 Van Natta 391 (1993), we held that there was no statutory requirement that a claimant first request reconsideration of a Determination Order which addressed a request for reclassification of a claim accepted as nondisabling. Based on the statutory scheme and the plain language of the statutes, we concluded in Driscoll that the reconsideration process set forth in ORS 656.268(5) and (6) was limited to accepted disabling claims. In reaching our decision in Driscoll, we interpreted ORS 656.262(6)(c), 656.268(9) and 656.268(11) as granting the claimant a right to request a hearing directly from a Determination Order which addresses claim reclassification.

SAIF argues that Driscoll is not controlling because it was issued before the Director adopted OAR 436-30-045(7). We disagree. We recently addressed the effect of OAR 436-30-045(7) in Brenda Guzman, 46 Van Natta 2161 (1994). There, based on our holding in Driscoll, we concluded that OAR 436-30-045(7) is inconsistent with the statutory scheme because it requires a claimant to request reconsideration prior to requesting a hearing on a Determination Order addressing claim classification. Accordingly, inasmuch as the rule conflicts with the statutory scheme, we gave it no effect. See Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992) (An agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule); Brenda Guzman, supra.

Reclassification

Having found that we have jurisdiction, we now address the classification issue. The Referee concluded that claimant had not established that there is a substantial likelihood that he will be entitled to an award of permanent disability. Claimant does not dispute that conclusion. Instead, claimant contends that his release to modified work establishes that he is temporarily partially disabled. We agree.

On June 14, 1993, Dr. Conner released claimant to work with a restriction against all lifting. (Ex. 2A). Claimant continued working for the at-injury employer until August 18, 1993, when he quit because he felt that the employer was not protecting him from further injury by failing to recognize his work restrictions against lifting. (Exs. 2A, 7-1). There is no evidence in the record that claimant was paid less than his regular wages while he continued working for the employer after his injury. SAIF does not dispute that claimant was released to a modified job, but argues that no temporary disability benefits were "due and payable" in this claim and that, based on ORS 436-30-045(5)(a), claimant's claim is not disabling. OAR 436-30-045(5)(a) provides that a claim is "disabling" if temporary disability is "due and payable."

Subsequent to the date of the Referee's order, we issued our decision in Sharman R. Crowell, 46 Van Natta 1728 (1994). In Crowell, we held that a claimant's receipt of regular wages for her modified work did not preclude a finding that the claimant's injury was disabling. In reaching that conclusion, we relied on Stone v. Whittier Wood Products, 124 Or App 117 (1993), which held that temporary partial disability (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 Crowell, the claimant was released to modified work at her pre-injury wage. We held that even though the rate of the claimant's TPD might be zero, the mere fact that the claimant was required by the compensable injury to work at modified employment meant that she was temporarily and partially disabled.

Thus, we concluded in Crowell that the claimant was disabled as a result of her injury, notwithstanding the fact that she might receive TPD at the rate of zero once her TPD was calculated. We emphasized in Crowell that the issue was whether the claim was disabling, not whether temporary disability was due and payable. We also found OAR 436-30-045(5)(a) inconsistent with the court's holding in Stone v. Whittier Wood Products, supra, since the rule equated disability with reduction in post-injury wages.

Here, because claimant was released to modified work, we conclude that his claim was disabling, notwithstanding the fact that he may receive TPD at the rate of zero once his TPD is calculated. Sharman R. Crowell, supra; Brenda Guzman, supra.

Finally, SAIF notes that, in response to the court's decision in Stone v. Whittier Wood Products, supra, the Department promulgated temporary rules for determining whether a worker who is released to a modified job is entitled to TPD. SAIF argues that under those temporary rules claimant has not proven that he would be entitled to TPD. However, the issue before us is not the extent of claimant's temporary and/or permanent disability. Rather, the issue before us is whether claimant's claim should be classified as disabling. We have found that claimant is entitled to TPD, even though the rate of TPD may be zero. Accordingly, claimant's claim is disabling. The extent of claimant's temporary or permanent disability is an issue to be decided at claim closure. Brenda Guzman, supra.

ORDER

The Referee's order dated January 20, 1994, as corrected on February 3, 1994, is reversed. The Determination Order is set aside. The SAIF Corporation is directed to reclassify the claim as disabling and process it according to law. Claimant's attorney is awarded 25 percent of any increased compensation, resulting from this order, not to exceed $3,800, payable directly by SAIF to claimant's attorney.

In the Matter of the Compensation of
CHARLES KURNICK, Claimant
Own Motion No. 93-0674M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

On November 29, 1993, the Board authorized the reopening of claimant's left knee injury claim for the payment of temporary disability compensation beginning the date claimant is hospitalized for the proposed knee surgery. By letter dated August 29, 1994, the SAIF Corporation notified the Board that claimant has decided not to proceed with the proposed surgery at this time. SAIF submits a form signed by claimant that confirms SAIF's representations. As a result of claimant's decision to forego the proposed surgery, SAIF requests that we "rescind" our prior order. We treat this request as a request for reconsideration of our November 29, 1993 Own Motion Order. For the following reasons, we deny that request.

Pursuant to OAR 438-12-065(2), SAIF had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if SAIF could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. OAR 438-12-065(2).

We acknowledge that, in the past, we have found that extraordinary circumstances exist justifying reconsideration of an order that authorized the reopening of an own motion claim based on a proposed surgery where the proposed surgery was not performed. See, e.g., Terry L Cleland, 45 Van Natta 2197 (1993) (the claimant cancelled the proposed surgery for "personal family reasons"); Brian A. Chambers, 45 Van Natta 2021 (1993) (the claimant's physician subsequently opined that, although the claimant would require the proposed surgery at some point in the future, he was currently functioning well without it). In such cases, we withdrew and reconsidered our prior orders. Reasoning that the claimants had failed to establish that they required surgery or hospitalization now or in the near future, we concluded that we were without authority under ORS 656.278(1)(a) to grant the requests to reopen the claims. Therefore, we denied the requests for own motion relief, noting that, should the compensable conditions require surgery or hospitalization in the future, the claimants could again request own motion relief at that time. Id.

After further consideration, we find that a claimant's failure to undergo a proposed surgery or other treatment requiring hospitalization does not constitute extraordinary circumstances that would justify reconsideration of an order outside of the deadlines imposed by OAR 438-12-065(2). We base that finding on the following reasoning.

ORS 656.278(1) gives the Board authority to authorize the reopening of a claim for which aggravation rights have expired. However, that authority is limited. Additional monetary benefits are limited by ORS 656.278(1)(a), which provides that, where a compensable injury worsens requiring surgery or hospitalization, "the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery[.]" (Emphasis added). Thus, by statute, a worker is not entitled to temporary disability compensation until his or her compensable condition has worsened requiring surgery or hospitalization and he or she actually undergoes the surgery or hospitalization.

Therefore, own motion orders that authorize the reopening of a claim based on a compensable worsening that requires a surgery or hospitalization that has not yet been performed are essentially "contingent" orders. Since surgery or hospitalization is a prerequisite for authorization for reopening, it follows that an own motion order may not authorize the payment of temporary disability benefits until that surgery or hospitalization occurs. ORS 656.278(1)(a). If surgery or hospitalization subsequently occurs, then the prerequisite would be met and there would be no need to issue a further order. On the other hand, if surgery or hospitalization does not occur, then the claim would not be reopened under the own motion order as the necessary prerequisite would not have occurred.

Here, the prerequisite has not occurred in that claimant has not undergone the proposed surgery. Therefore, the November 29, 1993 order remains a "contingent" order, since the necessary

prerequisite for reopening the claim for own motion relief has not yet occurred. Because the order remains contingent, there are no extraordinary circumstances that would justify reconsideration. Finally, to the extent that any prior orders allowed reconsideration based on extraordinary circumstances and reversed essentially contingent own motion orders based on the fact that the proposed surgery or hospitalization had not yet occurred, we disavow those orders.

Accordingly, SAIF's request for reconsideration of the Board's November 29, 1993 order is denied.

IT IS SO ORDERED.

December 27, 1994 Cite as 46 Van Natta 2502 (1994)

In the Matter of the Compensation of
DENNIS R. LEWIS, Claimant
WCB Case No. 94-02018
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of that portion of our November 29, 1994 Order on Review which awarded a 25 percent penalty on temporary disability due between February 16, 1994 and March 28, 1994 and temporary disability due between March 29, 1994 and the April 4, 1994 hearing. We had assessed these penalties because of: (1) SAIF's unreasonable failure to compute claimant's temporary disability after February 28, 1994, as required by temporary OAR 436-60-030, and (2) because of SAIF's unreasonable misclassification of claimant's claim.

SAIF requests that our order be amended to reflect that the 25 percent penalty be based on temporary partial disability, if any, due during the periods in question, rather than on "temporary disability." SAIF notes that our order also affirmed the Referee's finding that claimant's low back condition was compensable, which may entitle claimant to temporary total disability during the above periods. It asserts that it was our intent to base claimant's penalty on temporary partial, rather than temporary total, disability.

We disagree with SAIF's characterization of our intention. The penalties assessed in our order were based on "amounts then due" for SAIF's unreasonable claim processing. Our reference to "temporary disability" in the order section of our Order on Review was intended to encompass either temporary partial or temporary total disability.

If, as a result of our decision affirming the Referee's compensability finding, claimant is entitled to temporary total disability during the periods in question, this will constitute the "amount then due" for the purposes of calculating SAIF's penalties for its unreasonable claim processing. If claimant is not entitled to temporary total disability, then the 25 percent penalty awards will be based on temporary partial disability, if any, due during the relevant periods.

Accordingly, we withdraw our November 29, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our November 29, 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
NORMAN E. NIXON, Claimant
WCB Case No. C4-02991
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Schneider, et al., Claimant Attorneys
Industrial Indemnity, Insurance Carrier

Reviewed by Board Member Neidig and Hall.

On November 23, 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.

Here, the parties have agreed that a certain sum of money will be paid to claimant, and an attorney fee, commensurate with the Board rules, will be paid to claimant's attorney from that sum. Additionally, the CDA provides that "the carrier shall accelerate and pay in a lump sum any remaining payments due claimant under the Determination Order of September 7, 1994." (P. 3, Ln. 18-20).

We have previously held that approval of a lump sum award is expressly within the Director's discretion. ORS 656.230; Kevin E. Sahlfeld, 45 Van Natta 1779 (1993); Erven Simril, 43 Van Natta 629 (1991). Pursuant to the Director's former rules, the Board was without authority to authorize such an action.

Subsequent to the aforementioned decisions, the Director amended its rules regarding lump sum payments of permanent partial disability awards relating to claim disposition agreements. See OAR 436-60-060. Specifically, the current rule provides that a lump sum payment which is a part of a Claim Disposition Agreement (CDA) does not require further approval by the Division. See OAR 436-60-060(5). The Director's rule became effective August 28, 1994. (WCD Admin. Order 94-055).

Accordingly, because the CDA in this instance was signed by all the parties in November 1994, after the amended rules became effective, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved. An attorney fee of $1,625, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
FLORENCE L. ATKINSON, Claimant
WCB Case No. 94-00671
ORDER ON REVIEW
Kelley & Kelley, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of that portion of Referee Brazeau's order that affirmed an Order on Reconsideration which awarded 1 percent (1.5 degrees) scheduled permanent disability for loss of use or funnction of the right forearm (wrist). Claimant also contends that the Referee erred by denying her request to depose her treating physician. On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, claimant argued that she should be permitted to obtain a deposition from her treating doctor. Claimant contended that, because the arbiter's exam and subsequent report did not result in a chronic condition award, as she had anticipated, she should be permitted to depose her treating physician.

We agree with the Referee's conclusion that, because an arbiter had been appointed, ORS 656.268(7) prohibits the admission of medical evidence of the worker's impairment developed after the medical arbiter's report. Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993); Jim Vallejo, 46 Van Natta 1242 (1994). Accordingly, because the medical evidence claimant sought to obtain following the arbiter's report would not have been admissible, we agree with the Referee's ruling denying claimant's request to depose her treating physician.

Alternatively, we consider whether claimant's request to depose her treating doctor constituted a request for a postponement of the hearing. In this case, we conclude that claimant's failure to depose her treating doctor in anticipation of a chronic condition award based on an arbiter's report does not establish "extraordinary circumstances" beyond claimant's control sufficient to justify a postponement. See OAR 438-06-081; Georgia-Pacific Corp. v. Kight, 126 Or App 244 (1994). Specifically, in the present case, prior to the arbiter exam, both of claimant's treating physicians had addressed the impairment issue, with Dr. Smucker finding that any chronic condition was attributable to a prior injury, rather than the compensable injury. Furthermore, Dr. McWeeney found no detectable abnormalities in claimant's wrist. Under the circumstances, we do not find that claimant's surprise at the arbiter's failure to award a chronic condition award constitutes extraordinary circumstances for purposes of a postponement.

Extent of scheduled permanent disability

The Referee found that claimant failed to establish an entitlement to a chronic condition award for an inability to repetitively use her right wrist. On review, claimant disagrees with the Referee's finding that she had a previous injury which the doctors found to have caused her current wrist problems. Claimant argues that because the doctors were mistaken with respect to a prior injury, the Referee should have accepted her testimony that there was no prior injury or condition.

Rather than supporting a conclusion that claimant sustained a prior injury, we would interpret the medical opinions as suggesting that claimant had a preexisting right wrist condition at the time of her compensable December 1992 occupational disease claim. We would also be inclined to find that the medical evidence establishes that claimant is unable to repetitively use her right wrist.

Notwithstanding these interpretations and inclinations, claimant must still prove that her disability is due to the compensable injury. See ORS 656.214(5). In other words, her permanent impairment must be caused by the accepted injury and / or accepted conditions. OAR 436-35-007(1). "Impairment" means a decrease in the function of a body part or system as measured by a physician according to the measurement methods described in the American Medical Association Guides to the Evaluation of Permanent Impairment. OAR 436-35-005(5).

Here, assuming that claimant has a "chronic condition," the medical evidence does not attribute her impairment to her compensable condition. Accordingly, we conclude that claimant is not entitled to an additional permanent disability award.

ORDER

The Referee's order dated May 12, 1994 is affirmed.

In the Matter of the Compensation of
DANIEL L. BOURGO, Claimant
WCB Case No. 93-10892
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of that portion of Referee Galton's order that affirmed an Order on Reconsideration which awarded claimant 28 percent (89.6 degrees) unscheduled permanent disability. In its brief, the insurer contends that the Referee erred in refusing to admit Exhibits 46 (a letter generated by the insurer's attorney which was concurred in by one of the three physicians who comprised the medical arbiter panel) and 47 (a form purportedly copied form the AMA Guide to the Evaluation of Permanent Disability). On review, the issues are evidence and extent. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction. We substitute the word "Department's" for the word "Farmer's" in the first phrase of the first sentence of the third full paragraph on page 3.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, the insurer contends that the Referee erred in refusing to admit Exhibits 46 and 47 at hearing. Exhibit 46, dated October 4, 1993, is a letter from the insurer's attorney summarizing a September 29, 1993 telephone conversation initiated by the insurer's attorney to Dr. Dineen, one of the three physicians who was a member of the panel of arbiters who had examined claimant for the Department on August 4, 1993. Exhibit 47 is a copy of a form purportedly copied from the American Medical Association's Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised), 1990. We turn first to the admission of Exhibit 46.

The Referee, relying on Eilene E. Harding, 45 Van Natta 2017 (1993), sustained claimant's objection to the admission of Exhibit 46, reasoning that the exhibit was neither from nor concurred in by claimant's attending physician and was thus inadmissible subsequent medical evidence under ORS 656.268(7). The insurer argues that Exhibit 46 was a medical arbiter's report and, as such, could be considered at any time during or after completion of the reconsideration process. We agree with the Referee that Exhibit 46 is not admissible, but do so based on the following reasoning.

ORS 656.268(7) requires the Director to refer a claim to a medical arbiter or panel of arbiters if the basis for the objection to the notice of closure or determination order is a disagreement with the impairment used in rating a worker's permanent impairment. The statute further provides that:

> "The findings of a medical arbiter or panel of arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis supplied).

While this provision prohibits the admission of medical evidence concerning claimant's impairment that was developed after the medical arbiter's report, it does not prohibit the medical arbiter's report itself. Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). Such a principle was further confirmed by the 1991 legislative amendments to ORS 656.268(6)(a), which provides that: "Any medical arbiter report may be received as evidence at a hearing even if it was not prepared in time for use in the reconsideration proceeding." (Emphasis supplied). The court has recognized that this provision supported its decision in Pacheco-Gonzalez that ORS 656.268(7) does not prohibit the admission of a medical arbiter's report, even if it was not considered by the Department in issuing its reconsideration order. See Wickstrom v. Norpac Foods, Inc., 125 Or App 520 (1993).

The statutes and the case-law support a conclusion that a medical arbiter's report is admissible at hearing. However, neither statute directly addresses the issue presented here. That is, whether the statutes contemplate that a "supplemental" or "clarifying" report from the medical arbiter or panel of arbiters, which is generated after the initial arbiter report and the Order on Reconsideration, is likewise admissible as a medical arbiter's report under ORS 656.268(7) and 656.268(6)(a).

Arguably, the statutes are clear in that both provisions refer to a "medical arbiter report" in the singular. Thus, neither statute would apparently contemplate further reports from a medical arbiter or panel of arbiters. However, ORS 656.268(6)(a) contains the phrase "any medical arbiter report," which could be interpreted as allowing supplemental or clarifying reports from the medical arbiter to be treated as a medical arbiter report under the statutes provided that such a report "was not prepared in time for use in the reconsideration proceeding." In determining whether a supplemental or clarifying report from the medical arbiter is admissible, we find it helpful to review the legislative history regarding the two provisions.

The legislative history concerning the reconsideration process reveals a legislative purpose to provide a nonlitigious, less costly administrative forum for resolving extent of disability issues. A significant step in furthering this purpose was the implementation of the medical arbiter process during the 1990 Special Session. Testimony at the Hearings of the Joint Interim Committee indicated that amended ORS 656.268(7) was proposed to insure that medical professionals decided medical questions and to eliminate "dueling doctors." (Hearings of the Joint Interim Committee on Workers' Compensation, May 3, 1990, Tape 9, Side B). Testimony also indicated that the medical arbiter procedure was expected to save the workers' compensation system expense by reducing hearings. (Id. at Tape 2, Side B). This was further confirmed by the comments of Representative Shiprack during the House floor debates. He stated:

> "If there is a disagreement related to the impairment of your disability, then what we're going to have from now on, and should this bill pass, is what's known as a medical arbiter. One of the biggest single complaints that injured workers have today about the Workers' Comp [sic] system is when there is a dispute about extent of disability both sides go out and hire their own hired guns. We've talked about it on the floor. I recently talked to a carpenter in my district just this weekend who had had eight separate independent medical examinations on this one claim related to his knee. This would be cut off. There would be no more IME's on extent cases. And the medical arbiter's opinion would be binding." (House Floor Debates on SB 1197, May 7, 1990).

ORS 656.268(6)(a) was substantially amended in 1991. The amendments to the provision were added in response to the court's decision in Benzinger v. Or. Dept. of Ins. & Finance, 107 Or App 449 (1991). (House Labor Committee Hearings on HB 3584, June 5, 1991, Tape 161-162, Side B). In Benzinger, the court had upheld a circuit court's injunction requiring the Director to issue a reconsideration order within the statutory 15 day time limit regardless of whether the reconsideration process had been completed. Such a requirement created a further legal entanglement as to whether a referee could consider a "post-reconsideration order" medical arbiter report. This question was subsequently answered in the affirmative by the Pacheco-Gonzalez court. However, during the 1991 legislative session, the question remained unresolved.

The 1991 Legislature addressed these processing problems in the following manner. The number of days in which the Appellate Unit was required to issue a reconsideration order was increased from 15 calendar days to 18 working days. In addition, the following language was added to ORS 656.268(6)(a):

"If an order on reconsideration has not been mailed on or before 18 working days from the date of the receipt of the request for reconsideration or within 75 days where a notice for medical arbiter review was timely mailed, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or determination order was mailed on the 18th working day or where an order was timely mailed on the 75th day. Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." (Emphasis supplied).

This section was proposed by Representative Mannix after a question was raised concerning whether a medical arbiter's report could be used at hearing where the reconsideration was "deemed denied" by virtue of the expiration of the 75 day period. (House Labor Committee Hearings on SB 3584, June 6, 1991, Tape 165, Side A).

Inasmuch as the reconsideration process is mandatory under ORS 656.268, parties could not request a hearing concerning the extent of permanent disability until a reconsideration order was issued. The amendment to ORS 656.268(6)(a) provided the parties with a mechanism by which to request a hearing if the Appellate Unit was unable to complete its review and issue a reconsideration order within the statutory time-limit. It is within this context that the emphasized portion of the statutory amendment must be interpreted. That is, when viewed in light of the purpose behind the amendment, it is apparent that the provision was added to permit admission of an initial medical arbiter report that was requested, yet not completed, before the statutory time-limit for reconsideration expired.

The phrase "was not prepared in time for use at the reconsideration proceeding" is consistent with such an interpretation. The statutory amendment further confirms that the provision is intended to permit admission of evidence at hearing of a medical arbiter report that is designed for use by the Appellate Unit during the reconsideration process, but was not prepared in time for consideration prior to the issuance of the reconsideration order (whether actually or "deemed" issued).

Such an interpretation is likewise consistent with the intentions expressed regarding the medical arbiter and reconsideration process. In other words, while the parties can no longer request opinions from their respective medical experts, permitting them to solicit supplemental opinions from the medical arbiter would tend to further the very same "dueling doctors" and litigious system the legislature was attempting to avoid. Moreover, allowance of such a practice would undermine the objectivity of the arbiter and raise a question with regard to whether the arbiter had become a witness for one party or the other.[1]

Finally, to interpret ORS 656.268(6)(a) as allowing the admission of supplemental or clarifying medical arbiter reports would ignore the context in which the statute was amended. When both provisions are considered in light of the legislative history, we conclude neither provision allows the admission of a "supplemental" or "clarifying" medical arbiter's report which was prepared at the request of either party.[2] Therefore, we agree with the Referee that Exhibit 46 is not admissible.

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[1] We note that ORS 656.310(2) provides that medical reports submitted by either a claimant or a carrier are considered prima facie evidence of the matters contained therein provided that the physician rendering the report consents to submit to cross-examination. However, a medical arbiter or panel of arbiters is appointed by the Director to prepare a report on behalf of the Appellate Unit. Since the medical arbiter is neither intended to be a witness for a claimant nor a carrier, it would appear that an arbiter is not subject to cross-examination under ORS 656.310(2). Allowing a party to solicit further opinions from the medical arbiter would create a situation wherein the other party would likely wish to cross-examine the medical arbiter with regard to the supplemental or clarifying report. As noted above, there does not appear to be any authority which would compel a medical arbiter to submit to such an examination. We do not believe such a result was intended nor would it be fundamentally fair to all parties.

[2] We recognize that, under our interpretation of the statutory scheme, an aggrieved party's "post-reconsideration order" options in contesting an "erroneous" medical arbiter report will be limited. However, for the following reasons, we consider it unlikely that such circumstances will arise and even less likely that the aggrieved party will be without a remedy.

To begin, since the Appellate Unit is conducting the reconsideration proceeding, any significant discrepancies between the attending physician and medical arbiter findings should be identified and resolved prior to issuance of the reconsideration order. Granted, the time between the medical arbiter report and the reconsideration order is usually short. Nevertheless, to

To the extent that this decision conflicts with our prior holding in Lorenzo Orozco-Santoya, 46 Van Natta 150 (1994), the reasoning expressed in Orozco-Santoya is disavowed. Our holding in Ryan F. Johnson, 46 Van Natta 844 (1994), is consistent with today's decision. In Johnson, a medical arbiter's report stated that the report would be finished once testing information was available. Notwithstanding the arbiter's admonition, an Order on Reconsideration issued without the "completed" medical arbiter report. When a carrier sought admission of the "completed" medical arbiter report at hearing, we ruled that the report was admissible. In doing so, we reasoned that the subsequent report was based on medical evidence generated prior to the date of the reconsideration order and that a "clarification" report could be considered.

Based on the reasoning expressed in today's order, the "post-reconsideration order" report in Johnson could not be considered on the basis that it constituted a "clarification" report. Nonetheless, we adhere to the ultimate conclusion in Johnson that the "post-reconsideration order" medical arbiter report was admissible.

Inasmuch as the medical arbiter's initial report in Johnson contained the arbiter's express "pre-reconsideration order" acknowledgment that the report was incomplete and would not be finished until further testing data was available, we consider the "post-reconsideration order" report to represent completion of the arbiter's self-described "incomplete" report. In other words, given the arbiter's "pre-reconsideration order" representation, the subsequent "post-reconsideration order" report based on the "finished" test results in combination with the previously self-described "incomplete" report constitutes a medical arbiter report which was "not prepared in time for use in the reconsideration proceeding" as contemplated by ORS 656.268(6)(a). Consequently, consistent with the statute and our reasoning in this order, the "post-reconsideration order" report from the medical arbiter in Johnson could be considered.

The reasoning expressed in Anne M. Younger, 45 Van Natta 68 (1993) is likewise consistent with today's holding. In Younger, after issuance of an Order on Reconsideration, the Department announced that a supplemental medical arbiter examination had been scheduled because the initial arbiter report had neglected to provide measurements in accordance with the Department's requirements. In light of the Department's concession that the first examination and report had been incomplete, we found that the "supplemental" medical arbiter's report should be considered.

As with the Johnson holding, the "post-reconsideration order" report in Younger could not be considered on the basis that is was a "supplemental" medical arbiter report. Rather, since the additional report was compelled by the Department after its acknowledgment that the first examination and report were incomplete, we consider the "post-reconsideration order" report in Younger to represent completion of the Department's self-described incomplete report. In other words, given the Department's acknowledgment that the initial medical arbiter report was incomplete, the addition of the subsequent "post-reconsideration order" report constitutes a medical arbiter report which was "not prepared in time for use in the reconsideration proceeding" as contemplated by ORS 656.268(6)(a).

We now turn to the admissibility of Exhibit 47. ORS 656.283(7) sets the standards by which evidence is admitted in workers' compensation hearings. The statute specifies that the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). Referees have broad discretion when rendering procedural and evidentiary rulings. Lyle A. McManus, 43 Van Natta 863 (1991).

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further assist the Unit in performing its review function, the parties could immediately bring any significant discrepancies to the Unit's attention prior to issuance of the reconsideration order. Likewise, in the absence of a hearing request, the Appellate Unit may change or cancel an Order on Reconsideration containing an "inadvertent error or omission which affects the order." OAR 436-30-008(1), (3).

Finally, even if a reconsideration order issues based on an "erroneous" medical arbiter report, neither the referee nor the Board are obliged to follow the medical arbiter's findings. Rather, such an impairment determination is based on the preponderance of the relevant medical evidence. See Raymond L. Owen, 45 Van Natta 1528 (1993), aff'd Roseburg Forest Products v. Owen, 129 Or App 442 (1994). Consequently, when confronted with "erroneous" medical arbiter findings which are contrary to the preponderance of the remaining relevant medical evidence, it is unlikely that a referee or Board will defer to such "erroneous" conclusions.

The insurer argues that the Referee erred in failing to take administrative notice of the AMA's Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised). Here, the Referee found that there was no evidence to identify Exhibit 47 and to show that it was clearly different from the material provided by the Department to the panel to determine impairment. We agree and adopt his opinion on this issue. Consequently, we conclude that the Referee did not abuse his discretion in excluding Exhibit 47.

Extent of Unscheduled Permanent Disability

We adopt the Referee's conclusions and reasoning.

Attorney Fees/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, 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 counsel's statement of services and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 28, 1993 is affirmed. Claimant's attorney is awarded $1,300 for services on Board review, to be paid by the insurer.

Member Hall, specially concurring.

I concur with the majority's opinion regarding the admissibility of a "supplemental" or "clarifying" medical arbiter report. I write separately to register my disagreement with a portion of my colleagues' reasoning in footnote 2.

Specifically, I disagree with my fellow members' conclusion that, in the event that the medical arbiter's report contains a significant error, an available option for the parties is to alert the Appellate Unit of the apparent mistake. Considering the limited time constraints between issuance of the medical arbiter report and the reconsideration order, I do not consider this option to be realistic. As a practical matter, should such unfortunate circumstances arise, I believe that the parties will simply be left with an erroneous medical arbiter's report and the remaining admissible medical evidence.

In the Matter of the Compensation of
RANDY D. BOYDSTON, Claimant
Own Motion No. 94-0349M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Bruce D. Smith, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's September 14, 1994 Notice of Closure which closed his claim with an award of temporary disability compensation from May 7, 1992 through November 3, 1993. SAIF declared claimant medically stationary as of November 3, 1993. Claimant does not argue that his medically stationary date is incorrect or that he was not medically stationary at claim closure. Instead, claimant argues that he is entitled to a penalty for SAIF's unreasonable claims processing regarding the payment of his temporary disability compensation. We agree.

FINDINGS OF FACT

Claimant compensably injured his back on September 22, 1980, while working for SAIF's insured. On April 23, 1985, claimant's aggravation rights expired on the 1980 injury claim. By order dated May 10, 1994, Referee Nichols found SAIF responsible for claimant's current low back condition that required surgery in May 1992. That order was not appealed and has become final by operation of law.

By Own Motion Order dated August 11, 1994, the Board authorized the reopening of claimant's 1980 injury claim. The Board directed SAIF to provide temporary disability compensation beginning May 7, 1992, the date claimant was hospitalized for surgery. The Board also ordered SAIF to close the claim pursuant to OAR 438-12-055 when claimant was medically stationary. The Board's order was not appealed and became final by operation of law on September 12, 1994.

On August 26, 1994, SAIF paid claimant temporary total disability compensation for the period from May 7, 1992 to May 7, 1993.

Claimant's condition became medically stationary on November 3, 1993.

On September 14, 1994, SAIF paid claimant temporary total disability compensation for the period from May 7, 1993 to November 4, 1993. That same date, SAIF issued a Notice of Closure, declaring claimant medically stationary as of November 3, 1993 and awarding time loss from May 7, 1992 through November 3, 1993.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that he is entitled to a penalty for SAIF's unreasonable claims processing regarding the payment of his temporary disability compensation. We agree.

On August 11, 1994, we issued an order authorizing the reopening of claimant's 1980 injury claim. We directed SAIF to provide temporary disability compensation beginning May 7, 1992, the date claimant was hospitalized for surgery. We also ordered SAIF to close the claim pursuant to OAR 438-12-055 when claimant was medically stationary. This order was not appealed nor was reconsideration requested; therefore, it became final 30 days after the date it was mailed. ORS 656.295(8); 656.278(3). Thus, the order became final on September 12, 1994.[1]

Essentially, our August 11, 1994 order required the payment of two "types" of temporary disability benefits: (1) temporary disability benefits accruing from the date of our order forward; and (2) temporary disability benefits due from the date of surgery forward to the date of our order (retroactively awarded temporary disability benefits). We discuss the penalty issues regarding these two types of temporary disability benefits separately.

Temporary Disability Benefits Accruing From the Date of Our Order

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); Donna Anderson, 46 Van Natta 1160 (1994). In contrast, prior to claim closure, claimant may be procedurally entitled to temporary disability benefits.

Here, SAIF issued a Notice of Closure on September 14, 1994, which declared claimant medically stationary as of November 3, 1993 and awarded temporary total disability compensation from May 7, 1992 through November 3, 1993. Claimant does not contend that his medically stationary date is incorrect or that he was not medically stationary at claim closure. In any event, the medical record would not support such a contention.[2] Claimant's substantive entitlement to temporary disability benefits ended on his medically stationary date. Furthermore, the Court of Appeals has held that we may not impose a "procedural" overpayment by ordering a carrier to pay temporary disability benefits

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[1] We compute the time by excluding the day of the act or event from which the designated period of time begins to run, and including the last day unless it falls upon any legal holiday or on Saturday, in which case the period runs until the end of the next day which is not a Saturday or a legal holiday. ORCP 10A; ORS 174.120. See also Anita L. Clifton, 43 Van Natta 1921 (1991). Here, the 30th day after our August 11, 1994 order was September 10, 1994. Inasmuch as September 10, 1994 was a Saturday, the last day for reconsideration or appeal of the order was Monday, September 12, 1994. Because neither a request for reconsideration nor appeal was made, the order became final on September 12, 1994.

[2] On September 8, 1994, Dr. Dunn II, claimant's treating surgeon, opined that claimant was medically stationary as of November 3, 1993. Dr. Dunn's opinion is unrebutted. Furthermore, there is no evidence that claimant was not medically stationary at the time his claim was closed on September 14, 1994.

beyond a claimant's substantive entitlement to those benefits. Lebanon Plywood v. Seiber, supra; John L. Desmond, 45 Van Natta 1455 (1993).

In order to be timely, payment of temporary disability benefits accruing from the date of the order shall begin no later than the 14th day after the order is issued. OAR 436-60-150(4)(h); OAR 438-12-035(1) and (2). See Thomas L. Abel, 45 Van Natta 1768 (1993).

Our order was issued on August 11, 1994. Therefore, payment of temporary disability benefits accruing from the 14th day after August 11, 1994 should have begun on August 25, 1994. Furthermore, OAR 436-60-150(5) provides, in relevant part, that "[t]emporary disability shall be paid to within seven (7) days of the date of payment at least each 14 days." Thus, SAIF should have started payment of the accruing temporary disability benefits on August 25, 1994 and continued paying those benefits until claim closure or some provision of the law authorized it to terminate the benefits. Thomas L. Abel, supra. Here, SAIF made no payment of any accruing temporary disability benefits.

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, SAIF closed claimant's claim on September 14, 1994. However, until that date, claimant had an open, accepted claim for which the accruing temporary disability benefits were due. In addition, there is no evidence that any of the requirements in ORS 656.268(3) were met that would enable SAIF to unilaterally terminate claimant's temporary disability compensation prior to claim closure.

As discussed above, we are unable to award a procedural overpayment in the form of the temporary disability benefits accruing from the date of our order until claim closure. On the other hand, we find unreasonable SAIF's failure to pay these benefits on an open, accepted claim where there was no basis for SAIF to unilaterally terminate such benefits prior to closure. Lebanon Plywood v. Seiber, 113 Or App at 654; Donna Anderson, 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 August 11, 1994 through September 14, 1994. One-half of the penalty shall be payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10).

Retroactively Awarded Temporary Disability Benefits

In order to be timely, payment of temporary disability benefits must be made no later than the 14th day after the date any litigation authorizing retroactive temporary disability becomes final. OAR 436-60-150(4)(h); OAR 438-12-035(2). See Thomas L. Abel, supra. Here, the litigation involving the temporary disability award, our August 11, 1994 order, became final on September 12, 1994. Therefore, payment of the retroactively awarded temporary disability compensation was due no later than 14 days from that date, or on September 26, 1994.

On August 26, 1994, SAIF paid claimant temporary total disability compensation for the period from May 7, 1992 to May 7, 1993. On September 14, 1994, SAIF paid claimant temporary total disability compensation for the period from May 7, 1993 to November 4, 1993. Claimant became medically stationary on November 3, 1993, and is not substantively entitled to temporary disability benefits after that date. ORS 656.210; Lebanon Plywood v. Seiber, supra. Therefore, SAIF paid claimant all of the retroactive temporary disability benefits to which he was entitled. Furthermore, these benefits were paid before the due date of September 26, 1994. Accordingly, claimant is not entitled to a penalty for late payment of these benefits.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. BURFORD, Claimant
WCB Case No. 93-09178
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Emmons, Kropp, et al., Defense Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Brazeau's order which: (1) excluded Exhibit 14 (a post-reconsideration report from his attending physician); and (2) affirmed an Order on Reconsideration awarding 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of the right arm. On review, the issues are evidence and extent of scheduled disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

By Determination Order (DO) dated April 27, 1993, claimant was awarded 35 percent scheduled permanent disability for loss of use or function of his right arm. On a form provided by the Department of Insurance and Finance (Department), the insurer requested reconsideration of the DO. On the form, the insurer checked the boxes indicating that it disagreed with the rating of scheduled permanent disability and with the impairment findings used in rating disability and requested a medical arbiter examination.

Dr. Burr, medical arbiter, examined claimant on July 1, 1993. Based on Dr. Burr's report, the Appellate Unit issued a July 30, 1993 Order on Reconsideration which reduced claimant's scheduled permanent disability award to 17 percent. On or about August 3, 1993, claimant obtained counsel, who requested a hearing appealing the April 27, 1993 DO and the July 30, 1993 Order on Reconsideration. The Referee affirmed the Order on Reconsideration.

At hearing, claimant requested that the Referee consider a "post-reconsideration" report from Dr. Deems, claimant's treating physician. (Exhibit 14). Relying on Scheller v. Holly House, 125 Or App 454 (1993), the Referee declined to admit the proferred medical report on the ground that it was developed after the medical arbiter report. We agree with his decision to exclude that report. See also Pacheco-Gonzales v. SAIF, 123 Or App 312 (1993).

Claimant contends that the procedures established by ORS 656.268 and the Director's accompanying administrative rules did not provide him with adequate notice that his permanent disability award could be reduced pursuant to the insurer's request for reconsideration. In other words, claimant asserts that the aforementioned procedures were unconstitutional. To cure any defect in notice, claimant contends that Exhibit 14 (the post-medical arbiter report from Dr. Deems, the treating doctor) should be admitted into evidence.

However, we conclude that we need not resolve this constitutional issue, because even if Exhibit 14 was considered, our ultimate decision would not be affected. For the reasons discussed below, we find the medical arbiter's report more persuasive than the November 15, 1993 post-reconsideration report of Dr. Deem (Exhibit 14).

Extent of Disability

Claimant contends that the Referee erred in deferring to the medical arbiter's report. Rather, claimant asserts that, based on Dr. Deem's April 19, 1993 closing examination, he is entitled to an award of 35 percent scheduled permanent disability. We disagree.

We do not automatically rely on a medical arbiter's opinion in evaluating a claimant's permanent impairment. Instead, we rely on the most complete and well-reasoned evaluation of the claimant's injury-related impairment. Kenneth W. Matlack, 46 Van Natta 1631 (1994). We find Dr. Burr's report the most persuasive.

Dr. Burr, medical arbiter, examined claimant contemporaneous with the reconsideration process; whereas Dr. Deem's closing examination was performed nearly three months earlier. Thus, Dr. Burr's report more accurately reflects claimant's disability at the time of reconsideration. See ORS 656.283(7). Moreover, in his November 15, 1993 report, Dr. Deem concurred with Dr. Burr's loss of muscle strength findings and acknowledged that any difference in these findings was temporal, in that Dr. Burr's findings were more recent. Thus, Dr. Deem does not dispute Dr. Burr's loss of strength findings. Claimant, also, does not dispute the values awarded for loss of ranges of motion and for loss of strength based on Dr. Burr's report. Consequently, we rely on Dr. Burr's report in rating claimant's permanent impairment. Therefore, we affirm the Referee's finding that claimant has 17 percent permanent impairment.

Claimant next contends that he is entitled to an additional 5 percent permanent disability award based on a "chronic condition" under OAR 436-35-010(6). That provision grants a worker 5 percent if the preponderance of the medical evidence establishes that the worker is unable to repetitively use a body part due to a chronic and permanent condition resulting from the compensable injury. Id. 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).

Dr. Burr opined that claimant has a chronic and permanent medical condition arising from the accepted condition. Dr. Burr noted that claimant experienced a "charley horse" pain any time he did heavy lifting and that he had significant pain every time he lifted using his right arm in a flexed position. We find his opinion sufficient medical evidence on which to base a chronic condition award. See Douglas L. Tyree, 46 Van Natta 2374 (1994)(the medical evidence affirmatively established that the claimant had permanent limitations of no repetitive hand work). Accordingly, claimant is entitled to an additional 5 percent award.

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (5 percent scheduled permanent disability). ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994) on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated January 13, 1994 is modified. In addition to the 17 percent (32.64 degrees) scheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm for a total award of 22 percent (42.24 degrees). Claimant's counsel is awarded 25 percent of the increased compensation (5 percent scheduled permanent disability) created by this order, not to exceed $3,800. In the event the scheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra.

December 29, 1994 Cite as 46 Van Natta 2513 (1994)

In the Matter of the Compensation of
JOYCE C. CLARIDGE, Claimant
WCB Case No. 93-14570
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Galton's order which: (1) upheld the self-insured employer's denial of claimant's current left ear condition; and (2) declined to assess penalties or attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant contends that a current left ear condition is related to her compensable motor vehicle accident (MVA). In order to establish the compensability of her current condition, claimant must establish either that her condition and need for treatment was 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, 113 Or App 411, 414 (1992).

The Referee concluded that claimant had failed to prove that the compensable injury was the major contributing cause of the left ear condition. We agree, and further conclude that claimant has also failed to prove that her compensable injury is a material contributing cause of the left ear condition.

On March 15, 1993, claimant was involved in a compensable motor vehicle accident (MVA). She initially treated for low back strain (Exs. 10-3, 11, 12), and reported increasing cervical symptoms about two months after the accident. (Ex. 17-6). In June 1993, the employer accepted "low back strain." (Ex. 21).

Claimant received physical therapy two times per week from March 1993 through October 1993 (Ex. 17), and continued in January 1994. (Ex. 53A). She did not mention an ear problem or dizziness at any of those sessions.

On May 11, 1993, claimant first treated with Dr. Thomas, orthopedist, who diagnosed cervical and lumbar strain. (Ex. 19-2). Dr. Thomas did not report a history of dizziness. On June 24, 1993, on referral from Dr. Thomas, claimant was examined by Dr. Berkeley, neurosurgeon, for numbness down the left arm and pain in her neck. (Exs. 22, 23). Again, claimant did not give a history of dizziness.

Claimant retained an attorney for a possible third-party claim in relation to her compensable MVA. On August 3, 1993, the attorney requested information from Dr. Thomas concerning the conditions for which claimant was treating. (Ex. 30). Dr. Thomas reported that claimant's current cervical and lumbar spine problems, and radiculopathy in the right arm were related to the accident. (Ex. 29).

On August 5, 1993, claimant was examined by physicians from Medical Consultants Northwest. (Ex. 31). Claimant reported current complaints of low back pain, neck and shoulder stiffness, tingling and numbness of both arms, and headaches in the back of the head and neck and over the right eye. (Ex. 31-3). Claimant gave no history of ear complaints or dizziness.

On August 25, 1994, claimant consulted Dr. Grimm, neurological consultant, and asked him to review her case. (Exs. 33, 34). Dr. Grimm had previously seen claimant's son for a vestibular problem. (Tr. 58-59). For the first time since her MVA, claimant reported a sense of disequilibrium. (Ex. 33-3). Dr. Grimm also reported a history of falling to the left since March 1993. (Ex. 34-3). He also noted that claimant reported ringing in the left ear over the last ten years. (Id). Dr. Grimm opined that claimant probably sustained a mild inner ear concussion in the accident. (Ex. 33-4).

On October 13, 1993, Dr. Wilson, neurologist, was asked to review Dr. Grimm's report concerning disequilibrium. Dr. Wilson reported that claimant had not complained about disequilibrium during his examination on August 5, 1993 and that, if she had such a problem, it was not related to the MVA. (Ex. 43-1).

On November 15, 1993, claimant was examined by physicians from Western Medical Consultants. (Ex 47). The chief complaints noted were low back pain and neck pain. The physicians specifically noted that there was no evidence of an inner ear condition. (Ex. 47-3).

On January 12, 1994, audiological and vestibular studies were conducted at the request of Dr. Grimm. (Ex. 60-2). After reviewing the test results, Dr. Grimm stated:

> "My impression from [the testing] was that we had demonstrated cochlear damage in the left ear with a sensorineural hearing loss, consistent with her report of tinnitus; and

from other vestibular findings, the objective evidence consistent with the diagnosis of a visually compensated inner ear concussion syndrome. We have no prior set of data for comparison purposes." (Ex. 60-3).

Dr. Grimm then concluded, based on the history given by claimant, that the vestibular symptoms appeared to have emerged after the accident of 1993. He further concluded that claimant's tinnitus had worsened, given a now clearly abnormal audiogram. Id.

On February 23, 1994, Dr. Brown, otolaryngology specialist, examined claimant. He obtained a history of claimant's symptoms and performed various tests. Dr. Brown agreed that claimant had a left ear condition. He did not believe, however, that claimant's ear condition was caused by her MVA because, based on the description of the accident, there was not sufficient trauma to the head. (Ex. 65-12). Further, Dr. Brown stated that traumatically induced vestibular dysfunction would cause symptoms within a few days of the injury. (Id). Because medical reports for several months following the MVA did not mention such symptoms, Dr. Brown did not believe claimant's problem was traumatically induced. Additionally, Dr. Brown was certain that if claimant had hearing loss as a result of trauma during the MVA, she would have noticed it immediately and reported it to a physician. (Ex. 65-27).

Dr. Brown concluded that, because claimant had some left ear dysfunction as many as ten years prior to the MVA, and because there were no records to objectively show the condition of claimant's ear prior to the MVA, he could not state within a medical probability that there was a worsening of hearing loss or tinnitus after the MVA. (Ex. 65-28, 65-63). Based on results of testing, Dr. Brown thought that it was most likely that claimant had a problem in her ear that was not caused by trauma due to the MVA. (Ex. 65-76). Furthermore, if claimant's condition were traumatically induced, claimant would have expected improvement after the MVA. (Ex. 65-79). Here, claimant's condition had gradually worsened. (Tr. 30-32).

On March 8, 1994, Dr. Grimm opined that claimant's March 15, 1993 MVA was the major contributing cause of claimant's inner ear condition, and that it contributed to worsening of hearing loss and tinnitus in the left ear. (Ex. 66).

When the medical evidence is divided, we give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we conclude that Dr. Grimm's opinion is not entitled to such deference. First, after claimant's initial testing, Dr. Grimm related the left ear hearing loss and tinnitus to the 1993 MVA based on claimant's reporting to him that the symptoms began shortly after the MVA and began to increase in the summer of 1993. (Tr. 31). However, claimant was examined by at least four different physicians and participated in twice weekly physical therapy for several months after the MVA, but did not relate any disequilibrium or ear symptoms until she saw Dr. Grimm at the end of August 1993. In light of such evidence, we are not persuaded that Dr. Grimm had an accurate history of claimant's ear condition. Moreover, although testing demonstrated cochlear damage in the left ear with a sensorineural hearing loss, Dr. Grimm admitted that he did not have any prior data to compare claimant's ear condition before and after the 1993 MVA.

Finally, we find Dr. Grimm's opinion conclusory in comparison with Dr. Brown's opinion. See Somers v. SAIF, 77 Or App 259, 263 (1986)(opinions that are conclusory and not well-reasoned are not given much weight). After his abovementioned initial conclusions, Dr. Grimm merely stated, without explanation, that claimant's 1993 MVA was the major contributing cause of claimant's inner ear condition. (Ex. 66). On the other hand, although Dr. Brown agreed that claimant has a left ear condition, he explained in detail why he did not believe the condition was caused by the MVA. He further explained that there could be several other causes for the condition, but further testing was necessary. Accordingly, after our de novo review of the record, we conclude that claimant has not met her burden of proving that her compensable 1993 MVA is a material cause or the major cause of her current left ear condition. Accordingly, we affirm the Referee's opinion.

Penalties and Attorney Fees

We adopt the Referee's conclusion with respect to this issue.

ORDER

The Referee's order dated April 5, 1994 is affirmed.

In the Matter of the Compensation of
PAUL M. HUCK, Claimant
WCB Case No. 93-10933
ORDER ON REVIEW
Jolles, Sokol, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall, Turner-Christian and Haynes .

Claimant requests review of Referee Lipton's order which affirmed an Order on Reconsideration awarding no unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to prove any impairment attributable to the compensable injury. Therefore, the Referee affirmed the Order on Reconsideration which awarded no unscheduled permanent disability. We disagree that claimant failed to prove any impairment attributable to his compensable injury. Accordingly, we proceed to rate the extent of claimant's unscheduled permanent disability.

In rating the extent of unscheduled permanent disability, we apply the standards in effect at the time of claim closure. Here, the Notice of Closure issued on June 15, 1993. (Ex. 30). Therefore, we apply the standards for rating unscheduled permanent disability in the low back as found in WCD Admin. Order 6-1992, effective March 13, 1992. See former OAR 436-35-270 through 436-35-360.

Impairment

Claimant contends that impairment is established by a January 15, 1993 physical capacities evaluation concurred in by claimant's attending physician, Dr. Beck. We agree.

The physical capacities evaluation resulted in limitations in lumbosacral ranges of motion, as measured by an inclinometer. (Exs. 22-1, 24-1). The measurements, performed by a physical therapist, were specifically concurred in by Dr. Beck. (Ex. 26). Dr. Beck also attributed the losses in lumbosacral ranges of motion to the compensable injury. (Ex. 35). Dr. Eusterman, who performed a closing examination at the request of Dr. Beck, also endorsed the range of motion measurements obtained in the physical capacities evaluation. (See Ex. 25-4, 25-5).

The Referee declined to rely on Dr. Beck's opinion, finding his initial concurrence with Dr. Eusterman's report to be inconsistent with his subsequent opinion that claimant has permanent impairment attributable to his compensable injury. (Compare Exs. 26, 27, 35). We disagree.

We do not find Dr. Beck's partial concurrence with Dr. Eusterman's closing examination to be inconsistent with his opinion that claimant's range of motion losses are attributable to the compensable injury. (See Exs. 25, 26, 27, 35). Indeed, we note that Dr. Beck anticipated that claimant would have permanent impairment at the time he recommended a closing examination. (Ex. 20). Instead, we find Dr. Eusterman's conclusory comment that claimant has "no permanent impairment attributable to this work injury" to be inconsistent with his endorsement of the range of motion losses measured in the physical capacities examination. (Ex. 25-4). We find Dr. Eusterman's unexplained conclusion puzzling and unpersuasive. Therefore, we reject Dr. Eusterman's comment that claimant has no permanent impairment attributable to this injury.

Accordingly, we conclude that claimant has the following permanent impairment, as measured in the physical capacities evaluation:

lumbosacral flexion	40 degrees equal to 4.0 percent
lumbosacral extension	20 degrees equal to 2.0 percent
left side flexion	15 degrees equal to 2.0 percent
right side flexion	22 degrees equal to .6 percent
Sum, lost ranges of motion equals	8.6 percent.

(See Ex. 24-1). OAR 436-35-360(19) through (22).

Having found impairment, we turn now to the social/vocational factors pertaining to unscheduled permanent disability.

Social/Vocational Factors

Age

Claimant was over 40 years old at the time of determination. (See Exs. 1, 30). Therefore, he is entitled to a value of +1 for age. Former OAR 436-35-290(2).

Education

Claimant has a high school diploma. (Ex. 17A-3). Therefore, the value for formal education is 0. Former OAR 436-35-300(3)(a).

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 each job. Former OAR 436-35-300(4).

In the ten years prior to the June 15, 1993 determination, claimant had the following jobs:

Position	DOT Code	Strength	SVP	Duration
truck driver	905.663-014	medium	4	14 months
forklift driver	921.683-050	medium	3	21 months
plycor operator	569.685-046	heavy	3	15-1/2 years

(See Ex. 17A-5). Therefore, claimant's highest SVP is 4, which has a value of +3. Former OAR 436-35-300(4)(e).

Claimant does not have a current license or certificate of completion necessary for employment in a job with an SVP of 4 or less, nor has claimant achieved an SVP of 5 or higher in the ten years preceding determination. (See Ex. 17A, Tr. at 13-14). Therefore, claimant is entitled to a value of +1 for training. Former OAR 436-35-300(5).

The values for education are added (formal education = 0, SVP = 3, training = 1), resulting in a final education value of 4. Former OAR 436-35-300(6).

Adaptability

The adaptability value is determined by comparing claimant's prior strength with his residual functional capacity. Former OAR 436-35-310. Claimant's at-injury job required "medium" strength (truck driver, DOT code 905.663-014). Claimant's residual functional capacity (RFC) is "medium/light," based on Dr. Beck's comments on the January 15, 1993 physical capacities evaluation. (Ex. 26). Therefore, claimant is entitled to an adaptability value of 2. 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 1 is added to his education value of 4, the sum is 5. When that value is multiplied by claimant's adaptability value of 2, the product is 10. When that value is added to claimant's impairment value of 8.6, the result is 18.6 percent, which is rounded to 19 percent unscheduled permanent disability. Former OAR 436-35-280.

Accordingly, we modify the Order on Reconsideration and find claimant entitled to 19 percent unscheduled permanent disability for his low back condition.

ORDER

The Referee's order dated January 4, 1994 is reversed. The September 2, 1993 Order on Reconsideration is modified to award claimant 19 percent (60.8 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.

Board Member Haynes dissenting.

Because I believe claimant failed to carry his burden of proving that he has any permanent impairment due to the compensable injury, I dissent.

I would rely on Dr. Eusterman's closing examination report. Dr. Beck, the attending physician, specifically recommended an independent medical examination, and he personally selected Dr. Eusterman to conduct the examination. (Exs. 19, 20, 21). Dr. Beck also concurred with Dr. Eusterman's report. (Ex. 27). I find no basis for not relying on Dr. Eusterman's opinion.

After examining claimant and reviewing the physical capacities evaluation (Ex. 22), Dr. Eusterman concluded that claimant had no permanent impairment attributable to the compensable injury. (Ex. 25-4). In support of his conclusion, he noted that on physical examination there were no objective findings of impairment, other than those shown on the MRI. The MRI, however, revealed only noncompensable degenerative changes in the lumbar spine. (Ex. 10). I find Dr. Eusterman's opinion to be clear and well-reasoned, and I rely on it. Thus, I am persuaded that claimant has no permanent impairment attributable to the compensable injury. Therefore, he is not entitled to an award of unscheduled permanent disability. See OAR 436-35-007(1), 436-35-270(2), 436-35-320(1).

By contrast, I do not find Dr. Beck's opinion persuasive. He agreed "somewhat" with Dr. Eusterman's report, yet the only controversy he specifically identified was claimant's appropriate strength category. (See Ex. 26, 27). Thus, I conclude that Dr. Beck initially agreed with Dr. Eusterman's conclusion that there are no objective findings attributable to the compensable injury.

Later, however, in response to claimant's attorney's queries, Dr. Beck indicated that the major contributing cause of claimant's reduced ranges of motion was the December 1991 work injury. (See Exs. 34, 35). I find this opinion to be inconsistent with Dr. Beck's earlier concurrence with Dr. Eusterman's examination; specifically, with Dr. Beck's apparent agreement that there was no permanent disability attributable to the compensable injury. Accordingly, I am not persuaded by Dr. Beck's opinion because I find his opinions to be inconsistent and conclusory.

Therefore, I am persuaded that claimant has no permanent impairment attributable to the compensable injury, and I would affirm the Referee's order and the September 2, 1993 Order on Reconsideration.

In the Matter of the Compensation of
ALBERT H. IVERSON, Claimant
WCB Case No. 94-01305
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Chiropractor Dr. Toyas, pro se, requests review of Referee Podnar's order that affirmed the Director's order under ORS 656.327(2) denying reimbursement for chiropractic treatment for the period January 11, 1991 through June 10, 1993. On review, the issue is whether the Director's order is supported by substantial evidence.[1]

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

The Director issued an order pursuant to ORS 656.327 finding that claimant's chiropractic treatments, provided by Dr. Toyas for the January 11, 1991 through June 10, 1993 period, were not reimbursable, because the attending physician did not submit a written treatment plan for that period. The Referee agreed, finding that substantial evidence supported the Director's order.

Pursuant to ORS 656.327(2), the Director's order may be modified only if it is not supported by substantial evidence in the record. Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992).

Here, after our review of the record, we are unable to find a written treatment plan by Dr. Nash, claimant's attending physician, prescribing chiropractic treatment for the period in question. Dr. Nash prescribed chiropractic treatment in July and October 1990, but those prescriptions expired prior to claimant's current injury, sustained on December 3, 1990. (See Exs. 1-2, 2-2).

On November 9, 1993, Dr. Nash confirmed that he had authorized chiropractic treatments continuously from July 10, 1990 until the present. (Ex. 21). In justifying continued chiropractic treatment, Dr. Nash simply stated, "It is still my opinion that said treatment is helping improve [claimant], and is related to the work injury that has been the subject of my examinations and treatment as well." (Id).

The Director's rule, however, provides that medical services rendered by a provider other than the attending physician shall not be reimbursed unless carried out under a written treatment plan prescribed by the attending physician prior to the beginning of such treatment. OAR 436-10-040(3)(a), (b); see also ORS 656.245(3)(b)(A); James W. Nicholls, 46 Van Natta 1013 (1994). Thus, we find that Dr. Nash's November 1993 prescription for chiropractic treatment cannot be applied retroactively to authorize treatment already provided. Accordingly, we conclude that the Director's order is supported by substantial evidence.[2]

ORDER

The Referee's order dated April 22, 1994 is affirmed.

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[1] ORS 656.327(2) provides that "[i]f the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment." Because we have affirmed the Director's and Referee's orders which found that the chiropractic treatment during the period at issue was not compensable, we have no authority to require claimant to pay for the medical treatment.

[2] Member Gunn would note Dr. Toyas asks us to order payment based on "Biblical" law. Even if such law were applicable, it is clearly beyond my temporal authority and moral jurisdiction.

In the Matter of the Compensation of
MARIE E. KENDALL, Claimant
WCB Case No. 93-10201
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
James Thwing (Saif), Defense Attorney

Reviewed by Board Members Hall, Turner-Christian and Neidig.

Claimant requests review of those portions of Referee Hazelett's order that: (1) declined to award additional temporary disability; and (2) declined to assess penalties and related attorney fees for an allegedly unreasonable failure to pay temporary disability. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

In August 1992, claimant compensably injured her low back. In late July 1993, the employer mailed claimant a letter offering her a "temporary modified position with our recycling program" that consisted of sorting recyclable paper. (Ex. 37A). The job had been approved by claimant's attending physician. The letter provided the starting date and working hours and indicated that claimant would receive her "regular salary."

Based on claimant's failure to begin the modified work, the SAIF Corporation stopped paying temporary disability after August 4, 1993. Claimant requested a hearing. She sought reinstatement of her temporary disability, as well as penalties and attorney fees for unreasonable claim processing.

The Referee found that the notice of modified work complied with former OAR 436-60-030(5) (WCD Admin. Order 1-1992) and, therefore, SAIF was entitled to terminate temporary total disability (TTD).[1] On review, claimant argues that the letter notifying her of the modified job did not satisfy former OAR 436-60-030(5) because it did not reflect the job duration. We agree.

Under ORS 656.268(3)(c), TTD may be terminated before claim closure if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." Former OAR 436-60-030(5) more specifically provided that the insurer shall cease paying TTD when the injured worker "refuses or fails to begin wage earning employment prior to claim determination," under certain conditions. Those conditions are as follows. The attending physician must be notified of the physical tasks to be performed and must agree that the employment appears to be within the worker's capabilities. Furthermore, the employer must confirm the offer of employment in writing to the worker "stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities." Former OAR 436-60-030(5)(c) (emphasis supplied).

Substantial compliance with the procedural requirements of OAR 436-60-030(5) is insufficient to authorize a carrier to terminate TTD benefits. Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). As previously noted, the rule requires that the employer's written offer of employment must state "the duration of the job, if known." Former OAR 436-60-030(5)(c).

Here, the employer notified claimant that she was offered "a temporary modified position with our recycling program." (Ex. 37A). The employer's reference to a "temporary" job does not specify either the duration of the job or whether the employer knew the duration of the job. If the employer

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[1] Former OAR 436-60-030(5) (WCD Admin. Order 1-1992) has been renumbered OAR 436-60-030(12). (DCBS Admin. Order 94-055). No substantive changes were made to former OAR 436-60-030(5)(c).

knew the particular beginning and ending dates for the job, the rule required that these dates be included on the notice. On the other hand, if the employer did not know the specific duration of the job, the rule likewise mandated that the employer notify claimant that the dates were unknown.

The employer's notification neither provided the specific duration of the job nor indicated that such specifics were unknown.[2] In light of such circumstances, we conclude that the employer's mere reference to a "temporary modified position" does not constitute compliance with the strict procedural requirements of former OAR 436-60-030(5)(c). Because the employer failed to comply with the rule, it had no authority to terminate her temporary disability benefits. As a result of this conclusion, we decline to consider claimant's other challenges to SAIF's claim processing actions.

Consequently, we award claimant temporary disability commencing with SAIF's termination of such benefits and continuing until the benefits can be lawfully terminated. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800.

Penalty

Claimant requests penalties and attorney fees for SAIF's unreasonable resistance to the payment of compensation. Claimant is entitled to a penalty up to 25 percent of the amounts due if the carrier unreasonably refuses to pay compensation. ORS 656.262(10)(a). Because there is no evidence that the strict administrative requirements for unilateral termination of TTD benefits prior to claim closure have been met, we conclude that SAIF's termination of TTD payments was unreasonable. Claimant is entitled to a 25 percent penalty for the insurer's unreasonable termination of TTD benefits. Claimant's attorney shall receive one-half of this penalty in lieu of an attorney fee. ORS 656.262(10)(a).

ORDER

The Referee's order dated December 21, 1993 is reversed. The SAIF Corporation is directed to pay temporary disability benefits beginning from the effective date of its termination of such benefits until termination is authorized by law. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. A penalty is assessed equal to 25 percent of the temporary disability benefits due as of the November 22, 1993 hearing as a result of this order, to be equally divided between claimant and her attorney.

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[2] We note that the record could support a conclusion that the employer did know the duration of the modified position with its recycling program. The employer's workers' compensation coordinator testified at hearing that the employer set up the recycling room "as a way to employ people temporarily that needed modified jobs." (Tr. 43). The room had ergonomic equipment because most of the workers had back injuries. (Tr. 43-44). Because the employer specifically created the recycling position to employ workers that needed modified jobs, the employer presumably was aware of the duration of the position, i.e., it appears that the position existed as long as a worker was restricted to modified work. Thus, its failure to specify the duration would likewise constitute a violation of the procedural rule.

Board Member Neidig dissenting.

The majority concludes that SAIF had no authority to terminate claimant's temporary disability benefits, reasoning that SAIF did not comply with the strict procedural requirements of former OAR 436-60-030(5)(c) (WCD Admin. Order 1-1992). Because I am convinced that the majority misconstrues that rule, I dissent.

Former OAR 436-60-030(5)(c) provided that the employer must confirm an offer of employment in writing to the worker stating, among other things, "the duration of the job, if known. (Emphasis supplied). The majority interprets the rule to require that if the employer does not know the specific duration of the job, the employer must notify claimant that the job duration is unknown. The majority's interpretation changes the rule to say that the employer must notify the worker of the duration "if known, or unknown."

In Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986), the court discussed the predecessor to OAR 436-60-030(5). Former OAR 436-54-222(6) provided that the employer must provide the worker with a written offer of reasonable employment which states, among other things, "the duration of the job." Under that rule, the employer was required to specify the duration of the job in all circumstances.

In contrast, the version of the rule that we are interpreting requires the employer to state the duration of the job, only if known. In the present case, if the employer was unsure of the duration of the job, the employer was not required by former OAR 436-60-030(5)(c) to say anything at all about the duration of the job.

The record does not support a conclusion that the employer knew the duration of the job. I disagree with footnote 2 of the majority's order, where the majority notes that the record could support such a conclusion. The majority's conclusion requires a presumption that the employer could foresee that, no matter how many workers it had that were restricted to modified work, the employer could guarantee that there would be enough work in the recycling program to keep them all working. There is no basis in the record to support that conclusion.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
KAREN S. BOLING, Claimant
WCB Case No. 94-00517
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

The SAIF Corporation requests review of those portions of Referee Spangler's order that: (1) set aside its "de facto" denial of claimant's right arm and rib contusions and right shoulder AC joint separation; (2) awarded claimant a penalty-related attorney fee pursuant to ORS 656.382(1) for allegedly unreasonable claims processing; and (3) awarded claimant 20 percent (64 degrees) unscheduled permanent disability for her right shoulder condition, whereas an Order on Reconsideration had awarded 9 percent (28.8 degrees). On review, the issues are compensability, attorney fees and extent of unscheduled permanent disability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact, with the exception of the last ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm that portion of the Referee's opinion regarding the compensability of claimant's right arm and rib conditions. However, we disagree with his conclusion that SAIF "de facto" denied claimant's right shoulder AC joint separation for the following reasons.

Whether an acceptance occurs is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449, 454 (1992). In July 1992, claimant injured her right arm, ribs and shoulder when she slipped and fell at work. The initial diagnosis was contusion right shoulder, arm and ribs; claimant filled out a form 801 for bruised right arm, shoulder and ribs. (Exs. 1, 2 and 4). Subsequent to the initial emergency room treatment for these body parts, claimant was treated for a right shoulder strain. On August 14, 1992, SAIF formally accepted the claim for a shoulder strain. (Exs. 7 and 10).

In September 1992, claimant changed her treating physician to Dr. Hayes, who diagnosed her shoulder condition as "right AC joint separation," "right AC joint separation/shoulder strain," "right shoulder strain," and "right shoulder tendonitis." (Exs. 9-1 through 9-5, 13 and 16-2). Drs. Potter and Kullar also diagnosed claimant's condition as shoulder strain and/or tendinitis. These differential diagnoses of claimant's shoulder condition varied in concert with the waxing and waning of claimant's symptoms. (Exs. 19 and 24-7).

Despite the different terminologies used by the medical providers, there is no medical evidence that claimant sought treatment for a new or different shoulder condition from the one accepted by SAIF. Moreover, claimant testified that SAIF paid for her medical treatment and SAIF maintains that it had no intent to deny any condition resulting from the original injury. Thus, we find that claimant's current shoulder condition is the same condition that it has been since the original injury, even though different medical terminology has been employed, and conclude that SAIF did not "de facto" deny claimant's shoulder condition. See Leslie C. Muto, 46 Van Natta 1685 (1994) (Where different medical terminology employed, but claimant's current condition was the same condition that it had been since the original injury, no "de facto" denial found).

ORS 656.382(1) Attorney Fee

The Referee awarded claimant a $500 attorney fee for SAIF's unreasonable failure to accept or deny the claimed conditions. Claimant testified that all compensation had been paid. An insurer cannot unreasonably resist the payment of compensation that has been paid. SAIF v. Condon, 119 Or App 194 (1993). Thus, no attorney fee award pursuant to ORS 656.382(1) is due.

ORS 656.386(1) Attorney Fee

The Referee awarded claimant an assessed attorney fee of $2,500 pursuant to ORS 656.386(1) for her counsel's efforts at hearing in setting aside the "de facto" denial of claimant's right arm pain, rib contusions, and right acromioclavicular joint syndrome. As previously discussed, we have found that there has been no "de facto" denial of claimant's right shoulder condition. Thus, claimant finally prevailed at hearing over SAIF's "de facto" denial concerning two of the three conditions listed in the Referee's order (claimant's right arm pain and rib contusions). In light of such circumstances, the Referee's attorney fee award will 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 assessed attorney fee for claimant's counsel's services at hearing concerning the compensability of claimant's right arm pain and rib contusions is $2,000. 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Extent of Unscheduled Permanent Disability

SAIF contends that claimant's unscheduled permanent disability award should be reduced from 20 percent to 9 percent, as awarded by the Order on Reconsideration. We agree for the following reasons.

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 became medically stationary on May 27, 1993 and a Notice of Closure issued on June 18, 1993. Accordingly, the standards as provided in WCD Admin. Order 6-1992 apply to our rating of permanent disability.

The parties do not dispute the ratings of 1 for age and 1 for education. For workers who at the time of determination have a release to regular work, or who have returned to regular work, the value for adaptability is 0. Former OAR 436-35-310(2). Claimant was released to regular work on April 20, 1993 and returned to regular work. (Exs. 16-1 and 19-1). Consequently, the value for adaptability is 0.

We agree with the Referee that the arbiter's findings are persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986). However, in applying OAR 436-35-330 to rate the loss of range of motion in claimant's shoulder joint, we find that the impairment value for claimant's restricted range of motion in her right shoulder is 7.9, which we round to 8. OAR 436-35-007(11).

We now assemble the factors relating to claimant's unscheduled disability. Claimant's age value (1) and her education value (1) are added for a value of 2. OAR 436-35-280(4). This value is multiplied by claimant's adaptability factor (0) for a value of 0. This value (0) is added to the impairment value (8) to establish 8 percent unscheduled permanent disability.

Nevertheless, because SAIF requested that we affirm the Order on Reconsideration, we reverse the Referee and reinstate that portion of the Order on Reconsideration awarding 9 percent unscheduled permanent disability.

Claimant is entitled to an assessed attorney fee for services on Board review regarding the right arm and rib contusion conditions. 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 aforementioned compensability issues is $750, 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 May 3, 1994 is affirmed in part, modified in part, and reversed in part. The Referee's $500 attorney fee award under ORS 656.382(1) is reversed. In lieu of the Referee's increased unscheduled permanent disability award, the Order on Reconsideration award totalling 9 percent (28.8 degrees) unscheduled permanent disability is reinstated and affirmed. The Referee's "out-of-compensation" attorney fee award is reversed. That portion of the Referee's order which set aside a "de facto" denial of a right shoulder separation is reversed. In lieu of the Referee's $2,500 attorney fee award under ORS 656.386(1), claimant's attorney is awarded $2,000, to be paid by SAIF. The remainder of the order is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

Board Member Gunn dissenting.

I disagree with that portion of the majority's decision which holds that the SAIF Corporation's conduct did not constitute a "de facto" denial of claimant's right shoulder AC joint separation. Consequently, I must respectfully dissent.

As acknowledged by the majority, SAIF's acceptance expressly refers to a right shoulder strain. This record is devoid of evidence supporting a conclusion that SAIF accepted claimant's shoulder separation. The majority seeks to explain this omission by reasoning that the separation is only another diagnosis for "the same condition" that SAIF originally accepted.

The majority offers no medical opinion supporting its conclusion that a shoulder "separation" is the same condition as a shoulder "strain." In fact, the medical evidence supports the opposite conclusion. As recognized by the majority, Dr. Hayes, claimant's attending physician, diagnosed claimant's right shoulder condition as a separation, strain, and tendonitis. Inasmuch as Dr. Hayes separately listed these diagnoses, it cannot be persuasively argued that this physician was merely offering a .ariety of medical terminology to describe the "same condition."

I could share my colleagues' conclusion if SAIF had accepted claimant's right shoulder "condition." Based on the facts presented in this case, such an acceptance would encompass a "strain" and "separation." Nonetheless, SAIF did not issue such a general acceptance. To the contrary, it chose to limit its acceptance to a right shoulder "strain." Because it neither timely accepted nor denied claimant's right shoulder separation, SAIF's conduct constitutes a "de facto" denial. Furthermore, the payment of claimant's medical bills for her separation does not transform SAIF's actions into an "acceptance." See ORS 656.262(9); Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994).

Since I believe the majority's reasoning is both factually and legally flawed, I register this dissent. I would affirm the Referee's conclusion regarding the "de facto" denial issue, as well as the Referee's accompanying attorney fee award regarding that issue.

In the Matter of the Compensation of
ANA J. CALLES, Claimant
WCB Case No. 93-12389
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On December 8, 1994, we withdrew our November 9, 1994 Order on Reconsideration which: (1) republished our October 14, 1994 order that affirmed a Referee's order directing the SAIF Corporation to pay claimant's counsels the attorney fee portion of temporary disability compensation previously paid to claimant; and (2) awarded claimant a $600 insurer-paid attorney fee under ORS 656.382(2) for her counsel's services on Board review. We took this action to consider SAIF's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

SAIF contends that our attorney fee award is inconsistent with a court ruling and case precedent. Specifically, SAIF relies on an unpublished court ruling denying the claimant's petition for an attorney fee award resulting from the court's opinion in SAIF v. Rapaich, 130 Or App 216 (1994). In addition, SAIF refers us to the reasoning expressed in Strazi v. SAIF, 109 Or App 105 (1991). We do not consider either the ruling or decision to be controlling.

The Rapaich court affirmed a Board order, which had awarded a permanent disability award and an "out-of-compensation" attorney fee. Although the Board order had increased claimant's award beyond that granted by an Order on Reconsideration, claimant's award was still less than that granted by a Determination Order. Noting that it had already paid the full award granted by the Determination Order, the carrier contended that the Board had erred in directing the carrier to pay an "out-of-compensation" attorney fee.

Reasoning that the Board order had approved only an "out-of-compensation" attorney fee and did not provide for an attorney fee in addition to compensation, the court concluded that the carrier's assignment of error presented nothing for review. Consequently, the Rapaich court concluded that it would be premature to address the question of any potential recoupment of an overpayment because no such "additional" attorney fee had been granted by the Board's order.

Attached to its motion for reconsideration, SAIF has submitted pleadings from the parties in Rapaich which pertain to the claimant's petition for an attorney fee award under ORS 656.382(2). SAIF has also included the court's unpublished "Order Denying Petition for Attorney Fees," which sustained the carrier's objection to the claimant's petition.

Contending that the court's order resolved the same issue which is presently before us, SAIF argues that we must adhere to the court's ruling. To begin, we have serious reservations regarding the precedential value of an unpublished court ruling. In any event, even assuming that the ruling constitutes case precedent, we find it distinguishable.

As summarized above, the Rapaich court concluded that the carrier's appeal presented nothing for review because the Board order did not award an "additional" attorney fee. Under such circumstances, the court reasoned that it would be premature to address the question of any potential recoupment of an overpayment.

Here, in contrast, the Referee's order expressly awarded that "additional" attorney fee referred to in Rapaich and authorized the recoupment of the resulting overpayment. Since the Rapaich court was not presented with this situation, we do not consider its subsequent ruling regarding the claimant's entitlement to an attorney fee award under ORS 656.382(2) to be controlling.

SAIF also considers our decision to be contrary to the reasoning expressed in Strazi. In that case, the court affirmed a Board order which held that the claimant was not entitled to an attorney fee award under ORS 656.382(2) for successfully defending against a carrier's offset request. The Strazi court identified the dispositive issue as whether an offset for overpayment against future compensation is a reduction in a claimant's compensation award. Reasoning that an offset is a correction of an overpayment which neither reduces nor disallows any portion of a claimant's compensation award, the Strazi court agreed with the Board that a request for an offset is not a threat to the award of compensation.

Here, unlike in Strazi, SAIF did not request offset authorization. To the contrary, SAIF requested reversal of that authorization because it objects to the Referee's directive to pay the "additional" attorney fee award. Thus, Strazi is inapposite. As described in our prior order, SAIF initiated Board review to overturn the Referee's order which directed SAIF to pay an additional "out-of-compensation" attorney fee award. Inasmuch as that award constitutes "compensation" and since that award has not been disallowed or reduced as a result of our decision, we continue to hold that claimant's counsel is entitled to a carrier-paid attorney fee under ORS 656.382(2) for services expended on Board review.

Finally, turning to our affirmance of the Referee's "attorney fee" directive, SAIF challenges our decision insofar as it instructs SAIF to pay a fee directly to claimant's counsels for temporary disability compensation paid prior to the Referee's March 5, 1993 stipulation. Reasoning that it took steps to ensure that claimant's counsel would receive an "out-of-compensation" fee (i.e., it drafted a proposed stipulation which was received by claimant's attorney on December 29, 1992 for signatures), SAIF asserts that it would inequitable to require it to pay the "additional" fee. We disagree with SAIF's reasoning.

SAIF began paying claimant temporary disability benefits on December 7, 1992. Although claimant's attorney received the proposed stipulation on December 29, 1992, there is no indication when the agreement was actually prepared by SAIF. In any event, SAIF does not challenge our findings that it was aware of claimant's legal representation sometime in September 1992 and neglected to withhold or pay any of the temporary disability benefits to claimant's attorneys when it commenced payment of those benefits on December 7, 1992 or while the stipulation was awaiting claimant's attorney's signature and Referee approval. In light of such circumstances, we adhere to our prior conclusion that it would not be inequitable to require SAIF to pay claimant's attorneys the fee portion of the compensation paid prior to the March 5, 1993 stipulation.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our October 14, 1994 order, as reconsidered November 9, 1994, in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 30, 1994 Cite as 46 Van Natta 2526 (1994)

In the Matter of the Compensation of
LARRY S. KARNOSKI, Claimant
WCB Case Nos. 94-06506, 93-00436 & 93-07720
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Kevin L. Mannix, PC, Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee T. Lavere Johnson's order that: (1) awarded claimant a $750 attorney fee under ORS 656.382(1) for Liberty's allegedly unreasonable compensability denial of claimant's occupational disease claim for bilateral hearing loss; and (2) awarded claimant a $6,000 attorney fee under ORS 656.386(1) to be paid by Liberty (the non-responsible carrier). Continental Loss Adjusting (Continental) requests review of that portion of the Referee's order that set aside its "back-up" responsibility denial of claimant's claim for the aforementioned condition. On review, the issues are "back-up" denial, 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

"Back-up" Denial

We adopt the Referee's "Conclusions of Law and Opinion" on this issue, which appear on pages six through eight of the Amended Opinion and Order.

Penalties and Attorney Fees

The Referee found that Liberty's denial of compensability was unreasonable. We agree and adopt the Referee's "Conclusions of Law and Opinion" regarding the unreasonableness of the denial, which appear on pages eight through nine of the Amended Opinion and Order.

The Referee concluded that a penalty assessment for the unreasonable denial is not appropriate because no compensation is due claimant from Liberty. Consequently, the Referee assessed a $750 "penalty-related" attorney fee under ORS 656.382(1), instead of a penalty under ORS 656.262(10). See generally, Oliver v. Norstar, 116 Or App 333 (1992). We find that a penalty should be assessed, based on the following reasoning.

Subsequent to the Referee's order, in SAIF v. Whitney, 130 Or App 429 (1994), the court upheld the assessment of penalties against two insurers, although only one was substantively liable for the claim. Based on this precedent, we conclude that a penalty for unreasonable conduct may be assessed against an insurer even though no amounts are due under the claim against that insurer. Accordingly, inasmuch as Liberty's compensability denial was unreasonable, we conclude that a penalty of 25 percent of amounts due claimant (from Continental) is appropriate, rather than a penalty-related attorney fee. See Oliver v. Norstar, supra (When a penalty is assessed for unreasonable conduct, no attorney fee may be assessed based on the same conduct). This penalty shall be paid by Liberty and will be based on the compensation payable by Continental as a result of the Referee's order (as of the date of hearing).

In addition, we acknowledge Liberty's argument that it should not be required to pay an attorney fee for claimant's counsel's services at the hearings level, because it is not responsible for the claim. However, because we are bound by the court's pronouncements on this issue, we agree with the Referee that Liberty must pay that fee because its compensability denial placed claimant's compensation at risk. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon, 119 Or App 447 (1993); SAIF v. Bates, 94 Or App 666 (1989).

Further, because compensability was at issue on review (and Continental requested review regarding its "back-up" denial), claimant is entitled to an assessed attorney fee for services on review under ORS 656.382(2), payable by Continental. See SAIF v. Bates, supra; Raymond E. Merideth, Jr., 46 Van Natta 431, 434 (1994).

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 "back-up" denial is $900. 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. Finally, we note that claimant is not entitled to an attorney fee for services on review in responding to Liberty's appeal of the penalty and attorney fee issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 23, 1994, as amended June 2, 1994, is reversed in part and affirmed in part. That portion of the order that awarded a $750 "penalty-related" attorney fee to be paid by Liberty is reversed. In lieu of the award, Liberty is directed to pay a penalty of 25 percent of the amounts due claimant from Continental as of the date of hearing as a result of the Referee's order, one-half to be paid to claimant and one-half to claimant's attorney. The remainder of the order is affirmed. For services on review, claimant is awarded a $900 attorney fee, payable by Continental.

In the Matter of the Compensation of
JOHN J. RICE, Claimant
WCB Case Nos. 90-14069 & 90-12474
ORDER ON REMAND
Philip Schuster II, Claimant Attorney
Beers, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Rice v. Columbia Steel Casting, 129 Or App 82 (1994). The court has reversed our order, John J. Rice, 44 Van Natta 928 (1992), that reversed a Referee's order setting aside the insurer's denial of claimant's medical services claim for low back surgery. Concluding that our Order on Reconsideration did not explain the basis for our disposition of claimant's "law of the case" and "issue preclusion" arguments, the court has remanded for that explanation.

FINDINGS OF FACT

We adopt the Referee's findings of fact, including the "Findings of Fact" and "Ultimate Findings of Fact" contained in the July 3, 1991 Opinion and Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

The SAIF Corporation accepted claimant's original claim for a "low back strain." After a series of additional injuries, an arbitrator found that claimant's work activities after April 1, 1989 independently contributed to a worsening of his underlying low back condition and concluded that Connecticut Indemnity (now EBI Companies, "the insurer" herein) was responsible for that condition on April 17, 1990. The Board affirmed the arbitrator's order. John J. Rice, 42 Van Natta 2513 (1990), aff'd mem, Connecticut Indemnity v. SAIF, 109 Or App 329 (1991) (Rice I).

Dr. Franks performed a left discectomy and medial foraminotomy at L3-5 in October 1989. When claimant's symptoms persisted, Dr. Nash recommended additional surgery. The insurer denied claimant's aggravation claim and his request for medical services. Claimant requested a hearing. On November 8, 1990, the Referee initially upheld the insurer's denial.

On November 26, 1990, Dr. Nash performed a lumbar laminectomy and repaired a totally flail arch at L5-S1. In light of the "post-hearing" surgical findings by Dr. Nash, claimant requested reconsideration of the Referee's order insofar as it upheld the denial of medical services. On reconsideration, the Referee admitted claimant's "post-hearing" surgical evidence. Based on that evidence, the Referee held that claimant's November 1990 surgery presented a compensable claim for medical services because the surgery was reasonable and necessary and related to claimant's compensable low back condition.

The insurer requested review, contending that Dr. Nash's opinion was unreliable, based in part on its belief that claimant's 1989 pratfall at work never happened.[1] In reversing the Referee's order, we held that claimant failed to prove that an April 1989 pratfall at work caused his need for treatment at L5-S1 and further failed to prove that his L3-5 surgery caused his need for treatment at L5-S1. John J. Rice, supra (Rice II).

Claimant requested reconsideration and remand for admission of evidence concerning his February 13, 1992 surgery at L5-S1 (his second "post-hearing" operation), including the insurer's acceptance and subsequent "back-up" denial of a claim for that surgery, as well as related medical reports. In an amended motion for reconsideration, claimant raised "law of the case" and "issue preclusion" arguments. Specifically, he asserted that the issues of the compensability of his L5-S1 condition and its relationship to the April 1989 pratfall were resolved in his favor in Rice I.

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[1] The insurer took the position that claimant was not credible because he did not immediately report the April 1989 incident (pratfall). Therefore, the insurer argued that the doctor's opinion that the pratfall contributed to claimant's L5-S1 problems was based on an inaccurate history.

The Board's order on reconsideration adhered to its prior decision and denied the motion to remand.[2] Rice II. In doing so, the Board did not address the so-called "law of the case" and "issue preclusion" arguments. Claimant appealed.

Concluding that we did not explain the basis for our disposition of claimant's "law of the case" and "issue preclusion" arguments, the court has remanded the case for reconsideration and explanation. Accordingly, we proceed with our reconsideration.

The insurer contends that we should not address claimant's "law of the case" and "issue preclusion" arguments because they were not raised[3] until claimant amended his motion for reconsideration of our April 30, 1992 Order on Review. We disagree.

It is true that claimant's "law of the case" and "issue preclusion" theories or arguments did not expressly surface until reconsideration on Board review. However, we believe this occurred only because we erred in reframing and restating the issues in our Order on Review. We characterized claimant as contending that his L5-S1 condition was related to an alleged April 1989 pratfall at work or to the accepted L3-5 condition, solely because the previous L3-5 surgery caused the need for treatment at L5-S1. Rice II at 929. This characterization mistakenly narrowed claimant's theory of his case.

Throughout these proceedings, claimant's essential argument has remained constant; i.e., the November 26, 1990 L5-S1 surgery is compensable because it is related to his compensable back condition. (See Record at 100, 107). In light of such circumstances, we do not consider claimant's motion for reconsideration to have raised a "new" issue or theory. See also note 3, supra. Accordingly, we do not consider claimant's arguments on reconsideration to be inappropriate. In any event, we find the surgery compensable based on the following medical evidence.

As of the Arbitrator's 1990 order, claimant's compensable low back condition resulted from preexisting degenerative disease, which had been worsened by years of repetitive traumatic work exposure, an accepted low back strain condition, and multiple work injuries. See Kepford v. Weyerhaeuser Co., 77 Or App 363, 366 (1986) (Where the claimant's work injury and his work activities caused a worsening of his underlying condition, the claim is compensable); James E. Hammond, Sr., 43 Van Natta 504, 508 (1991).

The precise question at hearing was whether the proposed low back surgery was reasonable and necessary and related to claimant's compensable low back condition. At the time of the November 2, 1990 hearing, the surgery was expected to be performed at L3-5. However, during the November 26, 1990 surgery, Dr. Nash, treating surgeon, discovered that claimant's need for treatment arose from an L5-S1 problem. (Ex. 93). Thus, the pivotal issue is whether the surgery which was actually performed (at L5-S1) is compensably related to the accepted condition.

The medical evidence concerning causation is provided by Drs. Zivin and Nash. Noting that claimant's L5-S1 surgery was performed at the site of a congenital spinal malformation, Dr. Zivin, neurologist, opined that claimant's condition was not caused by his employment. (Ex. 90-2).

Dr. Nash, treating surgeon, noted claimant's multiple on-the-job injuries dating from 1980, including a 1989 pratfall. He opined that claimant's "injuries since 1990 and specifically the one in 1989 (pratfall) resulted in a total decompensation of stability due to the spondylolysis at the L5-S1." (Ex. 93-3). Based on his surgical findings and claimant's relief following release of the entrapped L5-S1 nerve, Dr. Nash concluded that claimant's need for L5-S1 surgery resulted from trauma at work. (Exs. 89, 93).

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[2] The Board denied claimant's request for remand because claimant did not explain how these medical reports or the insurer's conduct bear upon the compensability of the first post-hearing surgery (November 1990). Claimant did not renew his arguments for admission of additional "post-hearing" evidence thereafter.

[3] We set out the "law of the case" in our Order on Review:

"We note at the outset that claimant's L3-5 condition, a chronic back strain, resulted from an occupational disease. See John J. Rice, 42 Van Natta 2513 (1990), aff'd mem, Connecticut Indemnity v. SAIF, 109 Or App 329 (1991). The law of the case involving the L3-5 condition is that the condition was compensable as of an Arbitrator's Order dated April 17, 1990. See id." John J. Rice, supra, 44 Van Natta at 929.

We find no persuasive reason to discount Dr. Nash's opinion as the treating surgeon. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988) (The opinion of a worker's treating surgeon is entitled to particular deference, due to that physician's unique "hands on" opportunity to observe the worker's condition). Accordingly, based on Dr. Nash's opinion, we conclude that claimant's medical services claim for his November 26, 1990 back surgery is compensable.

Inasmuch as claimant has finally prevailed before the Board after remand from the court, he is entitled to a reasonable attorney fee for services before every forum. See ORS 656.388(1). Because we are affirming the Referee's order, we are likewise reinstating the Referee's $1,750 attorney fee award for services at the hearing level. Since claimant's counsel provided services before the Board and court, a reasonable fee for such efforts shall be awarded. Id. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services before the Board and court is $8,462.50. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and his 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, the Referee's order dated November 8, 1990, as reconsidered July 3, 1991, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTO RODRIGUEZ, Claimant
WCB Case No. 93-06124
SECOND ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
James Booth (Saif), Defense Attorney

Claimant requests reconsideration of our October 21, 1994 Order on Reconsideration that reduced his award of unscheduled permanent disability for a low back condition to 29 percent (92.8 degrees) from 31 percent (99.2 degrees) (pursuant to an Order on Reconsideration award which had been affirmed by a Referee's order). Seeking clarification of his counsel's attorney fee award, claimant requests reconsideration. On November 18, 1994, we abated our order to further consider claimant's request and provide the SAIF Corporation an opportunity to respond to claimant's motion. Having received SAIF's response, we proceed with our reconsideration.

We briefly summarize the procedural history of the case. A September 25, 1992 Determination Order did not award permanent disability. Claimant requested reconsideration. A May 26, 1993 Order on Reconsideration awarded 31 percent (99.20 degrees) unscheduled permanent disability for claimant's low back condition. The Order on Reconsideration also awarded an out-of-compensation fee equal to 10 percent of this increased compensation, not to exceed the maximum attorney fee awardable under OAR 438-15-040 ($2,800).

SAIF requested a hearing.[1] When the Referee affirmed the Order on Reconsideration, SAIF requested Board review. Our August 30, 1994 Order on Review reversed the Referee's order and modified the Order on Reconsideration to award no permanent disability benefits.

Thereafter, claimant requested reconsideration. On October 21, 1994, following abatement, we issued an Order on Reconsideration which modified the Referee's order. Specifically, we reduced claimant's unscheduled permanent disability award to 29 percent. Subject to that modification, we adhered to and republished our August 30, 1994 order.

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[1] Although both SAIF and claimant requested a hearing, claimant withdrew his request at the beginning of the hearing. (Tr. 3).

Claimant questions whether his attorney is entitled to an attorney fee of 10 percent of the 29 percent award on a fee of 25 percent of the award. ORS 656.268(6)(a) provides, in part:

> "In any reconsideration proceeding under this section in which the worker was represented by an attorney, the department shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker."

Claimant's claim was closed on September 25, 1992 by the Determination Order that did not award any permanent disability. On reconsideration, the Department awarded claimant 31 percent unscheduled permanent disability for his low back condition. The Order on Reconsideration also ordered SAIF to pay claimant's attorney an amount equal to 10 percent of any additional permanent disability. (Ex. 29).

Although the Referee affirmed the Order on Reconsideration, we have ultimately reduced claimant's unscheduled permanent disability award to 29 percent. Thus, we have modified claimant's "increased" permanent disability award (as granted by the Order on Reconsideration) from 31 percent to 29 percent. Likewise, claimant's attorney's "out-of-compensation" fee, under ORS 656.268(6)(a), is modified to 10 percent of claimant's 29 percent award.[2]

In reaching this conclusion, we look to the analysis applied in Vena K. Mast, 46 Van Natta 34 (1994), aff'd Mast v. Cardinal Services, Inc., 132 Or App 108 (1994). In Mast, we held that if the permanent disability award granted by an Order on Reconsideration is reduced, but the award still qualifies for a penalty under ORS 656.268(4)(g), then the amount of the penalty shall be reduced proportionately to the award reduction, i.e., 25 percent of the reduced permanent disability which is "then due." We apply the same principle to an attorney fee award under ORS 656.268(6)(a). Here, the Order on Reconsideration ordered SAIF to pay claimant's attorney an amount equal to 10 percent of any additional permanent disability. Although we have reduced claimant's "increased" permanent disability award from 31 percent to 29 percent, that award still qualifies for an attorney fee pursuant to ORS 656.268(6)(a).

Finally, claimant questions whether his attorney fee should be 25 percent of the increased compensation created by our reconsideration order. To begin, since our reconsideration order replaced our prior order, we actually reduced claimant's permanent disability award 2 percent from that affirmed by the Referee. Thus, there has been no increased award from the Referee's order to the Board's order. In any event, claimant did not request a hearing or Board review. Therefore, he is not entitled to a 25 percent "out-of-compensation" attorney fee. See OAR 438-15-040(1); OAR 438-15-055(1).

Consequently, we modify the attorney fee award granted by the May 26, 1993 Order on Reconsideration to 10 percent of claimant's 29 percent unscheduled permanent disability award. Accordingly, on reconsideration, as supplemented and modified herein, we republish our October 21, 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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[2] In its May 26, 1993 Order on Reconsideration, the Department inserted a maximum attorney fee award not to exceed the Board's maximum award under OAR 438-15-040 ($2,800). Inasmuch as ORS 656.268(6)(a) provides for an unlimited attorney fee, we have serious reservations regarding the validity of the Department's "maximum" award. See OAR 436-30-050(14). Nevertheless, we need not resolve that issue because claimant's out-of-compensation attorney fee does not exceed the $2,800 "maximum."

In the Matter of the Compensation of
JAY D. WATKINS, Claimant
WCB Case No. 93-13061
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Mongrain's order which affirmed an Order on Reconsideration's award of 9 percent (28.8 degrees) unscheduled permanent disability. The insurer cross-requests review of that portion of the Referee's order which found that claimant had timely filed his request for hearing. On review, the issues are timeliness of hearing request and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant's claim was closed by Determination Order on February 23, 1993. The standards for rating permanent disability in effect on that date are those found in WCD Admin. Order No. 6-1992, effective March 13, 1992.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his mid and low back while working as a carpenter. On February 23, 1993, his claim was closed by a Determination Order that awarded no permanent disability. On November 5, 1993, an Order on Reconsideration awarded 9 percent (28.8 degrees) unscheduled permanent disability.

The Referee concluded that claimant's functional capacity at the time of injury and his residual functional capacity (RFC) were the same, and awarded no value for adaptability when calculating the extent of claimant's unscheduled permanent disability. Thus, applying the impairment values found by Dr. Potter, medical arbiter, the Referee concluded that claimant's unscheduled permanent disability was 7 percent (22.4 degrees). Because the insurer did not request a reduction in the permanent disability award, the Referee affirmed the Order on Reconsideration.

Claimant contends that his functional capacity at the time of his injury was "very heavy" because he briefly worked with the concrete crew, and that his RFC is "light/medium." Therefore, he reasons that he is entitled to an adaptability value of 4. We disagree.

Under the applicable standards (see WCD Admin. Order No. 6-1992), the prior strength (physical demands) category for a worker's at-injury job is derived from the strength category assigned in the DOT for the worker's at-injury job. Former OAR 436-35-270(3d)(g). In determining the proper DOT job description, we consider the record as a whole, as it relates to job duties as well as strength demands to find the position which appropriately describes claimant's job at injury. See William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993).

Claimant's job-at-injury was that of a carpenter. Claimant testified that his work for the employer involved "some framing, a lot of finish work, and some concrete work." (Tr. 17). Claimant further testified that he did "mainly finish carpentry, and helped in remodeling, which is part of the finish carpentry." (Id. at 19). For approximately a month and a half during the year that claimant worked for the employer, he worked with the concrete crew because they were short of help. (Id).

According to claimant's own testimony, his concrete work occupied significantly less time than his work as a finish carpenter. See Christa Lee, 45 Van Natta 928 (1993). Consequently, after considering claimant's job duties, we find that the DOT job title most accurately reflecting claimant's at-injury job is carpenter (DOT 860.381-022). The strength requirement for a carpenter is medium.

Dr. Ewald, claimant's treating physician, limited claimant to lifting 34 pounds, which is in the "medium" strength category. Former OAR 436-35-270(3)(g)(C). (Ex. 13-1). Dr. Perry restricted claimant to lifting 50 pounds on a repetitive basis, which is in the "heavy" strength category. Former OAR 436-35-270(3)(g)(D). Dr. Perry also cautioned claimant from above-shoulder arm work. Because Dr. Perry placed only one restriction on claimant, the strength category is not reduced to the next lower classification. See former OAR 436-35-270(3)(e); former OAR 436-35-310(4). Dr. Potter, medical arbiter, found claimant capable of constantly lifting and carrying in the "medium/heavy" range, with permanent

restrictions from frequent crouching and twisting. With the two restrictions, Dr. Potter places claimant in the "medium" strength category. Former OAR 436-35-270(3)(g)(C).

Here, the preponderance of the evidence indicates that, even with restrictions, claimant is able to perform medium work following his injury. Therefore, the adaptability value is O. See former OAR 436-35-310(3). Accordingly, we affirm the Referee's conclusion that claimant is not entitled to an additional award beyond the 9 percent unscheduled permanent disability to which he has previously been granted.

In light of this conclusion, we decline to address the timeliness issue. In other words, even if we found claimant's hearing request to have been timely, we would agree with the Referee that claimant is not entitled to an additional permanent disability award.

ORDER

The Referee's order dated May 13, 1994 is affirmed.

December 30, 1994 Cite as 46 Van Natta 2533 (1994)

In the Matter of the Compensation of
DAVID WATTS, Claimant
WCB Case Nos. 94-02877 & 94-02363
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Howell's order that: (1) upheld the insurer's "de facto" denial of claimant's medical services claim for back surgery; (2) upheld the insurer's denial of claimant's medical services claim for a "Wonderbed"; (3) declined to assess penalties and attorney fees for allegedly unreasonable claims processing; and (4) did not award an assessed attorney fee for the insurer's alleged "pre-hearing" concession that claimant's proposed surgery was causally related to his compensable injury. On review, the issues are medical services, penalties and attorney fees.

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

Request for Surgery

Dr. Berkeley, claimant's attending physician, recommended a third surgery on claimant's low back. Claimant suffers from a noncompensable pulmonary condition that would significantly increase the risk of surgery. Because the Referee could not determine from the record whether Dr. Berkeley knew or considered claimant's pulmonary disease and because Dr. Berkeley relied upon claimant's unreliable subjective complaints, the Referee concluded that claimant failed to prove that surgery would be a reasonable form of treatment. Claimant argues that the Referee erroneously concluded that Dr. Berkeley did not take claimant's pulmonary condition into consideration. We disagree.

Dr. Platt, a neurologist, Dr. Dinneen, an orthopedist, and Dr. Klecan, a psychiatrist, examined claimant on behalf of the insurer. According to their report, claimant told them that his pulmonologist at the Veterans' Administration had told him that surgery "would kill him." (Ex. 94). Drs. Platt and Dinneen concluded that surgery would be very risky because of claimant's lung disease. They strongly recommended against any further lumbar surgery in view of the widespread pain syndrome, inconsistencies and minimal objective findings of right S1 radiculopathy. (Id). In a separate report, Dr. Klecan concluded that, for psychiatric reasons, claimant was a very poor candidate for surgery. (Ex. 93).

In a "check-the-box" letter, Dr. Berkeley did not concur with the report from Drs. Platt, Dinneen and Klecan. (Ex. 95). Even if we assume that Dr. Berkeley was aware of the seriousness of claimant's pulmonary condition on the basis of that "check-the-box" response, Dr. Berkeley failed to explain why he continued to believe that surgery on claimant was reasonable and necessary. Moreover, Dr. Berkeley failed to explain why surgery was warranted in light of the reports that claimant's subjective complaints are not reliable. In the absence of such explanations, we do not find Dr. Berkeley's opinion persuasive. We conclude that claimant has failed to prove that his proposed surgery is reasonable and necessary.

Assessed Attorney Fee

Claimant argues that he is entitled to an attorney fee under ORS 656.386(1) because the insurer conceded at hearing that claimant's proposed back surgery was causally related to the April 29, 1986 compensable injury. The insurer argues that claimant is precluded from raising this issue on appeal because he did not adequately raise the attorney fee issue at hearing.

At hearing, the insurer stipulated that claimant's current low back condition was related to his compensable injury. The insurer contested only whether the proposed surgery was reasonable and necessary. Claimant's attorney asserted at hearing that the causal relationship was a separate issue from the reasonable and necessary issue. (Tr. 10). Claimant's attorney stated that it could make a difference as far as penalties and attorney fees. However, claimant's attorney did not contend at hearing that he was entitled to an assessed fee because of the insurer's concession.

To preserve the issue of his entitlement to an attorney fee under ORS 656.386(1), at a minimum, claimant had to advise the Referee that he intended to pursue that issue at hearing. See Saedeh K. Bashi, 46 Van Natta 2253 (1994). Because claimant did not do that, we are not inclined to address the attorney fee issue on review.

In any event, we conclude that claimant is not entitled to an assessed attorney fee for obtaining a concession that the proposed surgery is causally related to his compensable injury. ORS 656.386(1) provides for an attorney fee where the claimant "prevails finally" from an order or decision denying the claim for compensation.

Here, claimant has met only one portion of the test, i.e., he has established that his proposed surgery is causally related to the compensable injury. Claimant has not established that his proposed surgery is reasonable and necessary. Therefore, his claim for medical services has not been found compensable. In other words, claimant has not "prevailed finally" over an order or decision denying his claim for compensation pursuant to ORS 656.386(1). Consequently, claimant is not entitled to an assessed attorney fee.

"Wonderbed"

Claimant argues that the Referee erred in determining that Dr. Berkeley's report was insufficient to establish that the prescribed "Wonderbed" was compensable. We disagree.

Medical services provided pursuant to OAR 436-10-040(8) are compensable, whether they are palliative or curative, so long as they are reasonable and necessary, they are the result of the compensable injury, and claimant has established with particularity why he needs the service when the majority of workers with similar injuries do not. Rager v. EBI Companies, 102 Or App 457 (1990), mod 107 Or App 22 (1991); Elixir Industries v. Lange, 100 Or App 492 (1990).

Here, Dr. Berkeley reported that the major contributing cause of claimant's need for a "Wonderbed" is his compensable injury. Dr. Berkeley also stated that the "Wonder Bed will not improve [claimant's] condition but only would allow [claimant] to sleep more comfortably." (Ex. 106). Dr. Berkeley's comment fails to establish, with particularity, why the nature of claimant's back injury, or the process of recovery, requires this type of treatment. See Diana M. McCoy, 46 Van Natta 2220 (1994) (medical evidence supporting the claimant's medical services claims for a hot tub and a water bed did not satisfy the particularity requirements of OAR 436-10-040(8)).

Accordingly, we find that claimant has not established, with particularity, why he needs a "Wonderbed" when the majority of workers with similar back conditions do not. We conclude that claimant has not met the minimum requirements set forth in OAR 438-10-040(8). Therefore, claimant has failed to establish the compensability of the "Wonderbed."

Penalties and Attorney Fees for Unreasonable Delay

Finally, claimant argues that he is entitled to a penalty related attorney fee for the insurer's unreasonable delay in accepting or denying his medical services claim for surgery. Because we have concluded that claimant's medical services are not compensable, there were no amounts then due on which to base a penalty under ORS 656.262(10) or unreasonable resistance to the payment of compensation to warrant an attorney fee under ORS 656.382(1).

ORDER

The Referee's order dated June 14, 1994 is affirmed.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 46

(Pages 2137-END)

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

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

OCTOBER-DECEMBER 1994

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Cite as 320 Or 175 (1994) September 29, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Melvin L. Martin, Claimant

MELVIN L. **MARTIN**, Respondent on Review,
v.
CITY OF ALBANY and SAIF CORPORATION, Petitioners on Review.
(WCB 90-20361; CA A73640; SC S40765)

In Banc
On review from the Court of Appeals.*
Argued and submitted May 10, 1994.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for petitioners on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, argued the cause for respondent on review.

DURHAM, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for reconsideration.

* Judicial Review from Workers' Compensation Board, 124 Or App 434, 861 P2d 405 (1993).

---

320 Or 177> The issue in this workers' compensation case is whether the Board had authority to hear this claim for medical services arising from a doctor's recommendation that claimant should receive medical treatment[1] in the future. The pertinent statute, ORS 656.327(1)(a), permits an insurer to request a review of medical treatment by the Director of the Department of Consumer and Business Services[2] if the insurer

> "believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services * * *."

The Court of Appeals held that the statute is not ambiguous, that the director's statutory authority to review medical treatment does not apply to requests for future medical treatment and that, for that reason, the Board had authority to decide this case. *Martin v. City of Albany*, 124 Or App 434, 861 P2d 405 (1993) (per curiam), citing *Jefferson v. Sam's Cafe*, 123 Or App 464, 861 P2d 359 (1993)). On review, we affirm the decision of the Court of Appeals.

In 1972, claimant suffered a compensable back injury. He underwent back surgeries in 1984, 1988, and 1989. Dr. Burchiel, a neurosurgeon, saw him on June 7, 1990, and recommended that claimant would be a good candidate for a procedure called spinal cord stimulation, if claimant did well on a psychological screening. A second neurosurgeon, Dr. Collada, saw claimant on August 21, 1990, and made a recommendation similar to Dr. Burchiel's. Dr. Hennings, a psychologist, evaluated claimant and recommended that he was not a good candidate for surgery, but said that there was a possibility that the recommended procedure would be successful.

320 Or 178> On October 11, 1990, claimant's lawyer wrote to employer, asking about the status of the authorization for the medical treatment. On October 22, 1990, employer requested review of the recommended medical treatment by the director of DIF under ORS 656.327(1)(a). On December 5, 1990, claimant's lawyer wrote to DIF asking about the status of its review of the proposed medical treatment. On December 12, 1990, DIF sent a notice to show cause requesting that employer provide evidence regarding the treatment.

---

[1] The Workers' Compensation Law, ORS chapter 656, does not specially define "medical treatment." In this opinion, we use "medical treatment" to refer to medical services, including surgery, provided for a compensable injury pursuant to ORS chapter 656.

[2] The Department of Consumer and Business Services was known as the Department of Insurance and Finance (DIF) when the Board decided this case. The name was changed pursuant to Oregon Laws 1993, chapter 744, section 10.

Claimant chose a different course. He requested a hearing under ORS 656.283 before the Hearings Division. By the time of the hearing on January 16, 1991, employer had neither accepted nor formally denied claimant's request to pay for the surgery. DIF had begun to process a medical treatment review, but had not issued an order. The referee concluded that the recommended treatment was "appropriate treatment for Claimant and that it is materially related to his work injury."

On review, the Board held that the referee lacked jurisdiction over issues surrounding the proposed medical procedure, because

> "disputes regarding *proposed* medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327." (Original emphasis.)

According to the Board, because ORS 656.327 provided a procedure for resolving a dispute over proposed medical treatment, insurer's "'de facto' denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division." As noted, the Court of Appeals reversed the Board.

Whether the Board and Hearings Division have authority to address a claim for future medical treatment is an issue of statutory construction. We turn to the relevant statutes. ORS 656.283(1) provides:

> "Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

Claimant argues that he requested a hearing pursuant to that statute to obtain an order compelling insurer to pay for treatment that his doctors recommended.

320 Or 179> Insurer contends that the Board had no authority to hold the requested hearing by operation of two statutes, ORS 656.704(3) and 656.327(1). ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter.*" (Emphasis added.)

ORS 656.327(1) and (2) provide:

> "(1)(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer of self-insured employer shall so notify the parties and the director.
>
> "(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.
>
> "(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section.

> "(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the <320 Or 179/180> worker and may examine the worker. Notwithstanding ORS 656.325(1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the findings of the director shall be submitted to the parties within 30 days of the request for review. The findings of the director regarding the treatment in question shall be prepared in such form and manner and shall contain such information as the director may prescribe. Within 10 days of making the findings, the director shall issue an order based upon the findings. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a hearing on the order. If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record."

We first address whether ORS 656.327(1) authorizes director review of a recommendation for future medical treatment. If not, then the last sentence of ORS 656.704(3) does not exclude the dispute from the matters concerning a claim for which claimant may request a hearing under ORS 656.283(1).

To discern the legislature's intention, we begin at the first level of analysis with the text and context of the statute in question. The statutory text "is the starting point for interpretation and is the best evidence of the legislature's intent." *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). We observe rules of construction "that bear directly on how to read the text," such as

> "the statutory enjoinder 'not to insert what has been omitted, or to omit what has been inserted.' ORS 174.010. Others are found in the case law, including, for example, the rule that words of common usage typically should be given their plain, natural and ordinary meaning." *Id.* at 611.

We also consider, at the first level of analysis, the context of the statute in question, "which includes other provisions of the same statute and other related statutes." *Id.* Only if the legislature's intent is not clear, after completion of <320 Or 180/181> the first level of analysis, do we proceed to the second level of analysis in which we consider legislative history. *Id.*

The legislature used the present verb tense in three places in ORS 656.327(1)(a) to describe the conditions for requesting director review of a medical treatment dispute. The use of a particular verb tense in a statute can be a significant indicator of the legislature's intention. In *Gettman v. SAIF*, 289 Or 609, 614, 616 P2d 473 (1980), the Board had reduced a worker's permanent disability award, because it found that he had a "potential" for retraining. We noted that the statute permitted that result only if the claimant could hold a "suitable occupation," which the statute defined as one that the claimant "is able to perform after rehabilitation." *Id.* at 614. The court said:

> "We conclude that the language of this statute, which speaks in the present tense, precludes cancellation of a permanent total disability award based upon a speculative future change in employment status. In other words, whether this claimant is permanently totally disabled must be decided upon conditions existing at the time of decision, and his award of compensation for permanent total disability can be reduced only upon a specific finding that the claimant presently is able to perform a gainful and suitable occupation." *Id.*

See also 1000 Friends v. LCDC, 292 Or 735, 746, 642 P2d 1158 (1982) (the use of the word "threaten" in its present tense in a land use statute indicated a legislative intention to exclude a future tense meaning for the term).

As those cases suggest, we do not lightly disregard the legislature's choice of verb tense, because we assume that the legislature's choice is purposeful. In most cases, we best effectuate the legislative intention by giving effect to the plain, natural, and ordinary meaning of the verb tense chosen by the legislature.

Although the legislature's choice of verb tense in ORS 656.327(1)(a) is significant, the statute contains other words, such as "medical treatment," that render the legislature's intention unclear. The term "treatment" is defined as "the action or manner of treating a patient medically or surgically." Webster's Third New International Dictionary 2435 (unabridged 1993). If we apply that definition, the key **<320 Or 181/182>** statutory phrase, "is receiving medical treatment," plausibly could be read to mean that, if a party or the director satisfies the prerequisites for review, then the director's review authority commences when the doctor commences the act of treating a claimant, medically or surgically, to improve the claimant's condition, and the claimant "is receiving" the doctor's medical or surgical care. Under that construction, a doctor's recommendation to an insurer that a claimant receive medical treatment in the future is not within the director's review authority, because it is not a present application of medical or surgical methods and techniques, the claimant is not yet "receiving" the recommended medical treatment and, because of that fact, the insurer cannot say, as ORS 656.327(1)(a) requires it to say, that it *believes* that the claimant *is receiving* medical treatment that "*is* excessive, inappropriate, ineffectual or in violation of rules." (Emphasis added.) The Court of Appeals has held that that reading is the only plausible construction of the director's authority under ORS 656.327(1)(a). *Jefferson v. Sam's Cafe, supra,* 123 Or App at 466. Although we do not agree that the statute is free of ambiguity, that reading appears to be the most likely reading in view of the legislature's repeated use of the present verb tense in the statute and the ordinary meaning of the term "treatment."

What appears to be the most likely reading of the text of ORS 656.327(1)(a) is not the only plausible reading. The legislature also plausibly could have meant "treatment" to include a medical determination that the claimant should undergo some medical treatment in the future. Under that reading, the director would have authority to review a recommendation for future medical treatment. We conclude that the text does not make it clear that the legislature intended to adopt one of these plausible constructions and reject the other.

We next examine the context of ORS 656.327(1)(a) to determine whether the legislature made its intention clear through another subsection of that statute or another related statute. ORS 656.327(2), quoted above, requires the director to review the medical treatment, to make findings regarding the treatment, and to issue an order based on the findings. Any party, including the medical service provider, may **<320 Or 182/183>** request a hearing on the order. The order may declare the medical treatment "to be not compensable" and, in that case, the claimant is not obligated to pay for the treatment. The order is reviewable by the Board under ORS 656.283.

Another part of the context of ORS 656.327(1)(a) is ORS 656.254(3)(a).[3] ORS 656.327(2) and 656.254(3)(a) support what we have described as the meaning of ORS 656.327(1)(a) that the legislature

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[3] ORS 656.254(3), which was added by Oregon Laws 1987, chapter 884, section 27, provides:

"In accordance with the provisions of ORS 183.310 to 183.550, if the director finds that a health care practitioner has:

"(a) Been found, pursuant to ORS 656.327, to have failed to comply with rules adopted pursuant to this chapter regarding the performance of medical services for injured workers or to have provided medical treatment that is excessive, inappropriate or ineffectual, the director may impose a sanction that includes forfeiture of fees and a penalty not to exceed $1,000 for each occurrence. If the failure to comply or perform is repeated and willful, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

"(b) Had the health care practitioner's license revoked or suspended by the practitioner's professional licensing board for a violation of that profession's ethical standards, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years or the period the practitioner's license is suspended or revoked, whichever period is the longer.

"(c) Has engaged in any course of conduct demonstrated to be dangerous to the health or safety of a workers' compensation claimant, the director may impose a sanction that includes forfeiture of fees and a penalty not to exceed $1,000 for each occurrence. If the conduct is repeated and willful, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

"(d) Has failed after January 1, 1989, to participate in a continuing education program that meets the requirements of ORS 656.329, the director may impose a sanction that includes forfeiture of fees and may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants until the health care practitioner participates in the continuing education program."

most probably intended. ORS 656.254(3)(a) authorizes the director, in the exercise of authority to review medical treatment pursuant to ORS 656.327(2), to find a health care practitioner

> "*to have failed* to comply with rules * * * regarding the performance of medical services for injured workers or *to have provided* medical treatment that *is excessive, inappropriate or ineffectual* * * *." (Emphasis added.)

320 Or 184> If the director makes one of those findings after reviewing medical treatment, ORS 656.254(3)(a) authorizes the director to "impose a sanction including forfeiture of fees and a penalty not to exceed $1,000 for each occurrence." The legislature used the past perfect verb tense in ORS 656.254(3)(a) to describe the health care practitioner's conduct that the director may sanction. That suggests that director review under ORS 656.327 concerns medical treatment that the health care practitioner already has administered, at least to the point that the challenged treatment may warrant a sanction. Nothing in the text of ORS 656.254(3)(a) suggests that the legislature intended to authorize the director to sanction a doctor merely for recommending a future medical treatment.

Under our analysis of the context of ORS 656.327(1)(a), we think it unlikely that the legislature intended to apply the procedures for medical treatment review and sanctions to a doctor's recommendation for a future medical treatment that the doctor has not yet provided and the injured worker has not yet received. We cannot say, however, that the context makes the legislative intention clear. Accordingly, we turn to legislative history. *See Weidner v. OSP*, 319 Or 295, 301, ___ P2d ___ (1994) (illustrating principle that a review of legislative history is necessary under the *PGE v. Bureau of Labor and Industries* template when the court can discern one most likely statutory meaning from the text and context, but cannot rule out other plausible meanings).

The director's authority to review medical treatment under ORS 656.327(1)(a) was created in 1987 as a part of House Bill 2900. Or Laws 1987, ch 884, 29. In that bill, the legislature also enacted ORS 656.254(3) to authorize the director to impose sanctions against health care practitioners for providing inappropriate medical treatment, suffering a license revocation or suspension for violation of professional ethical standards, engaging in a course of conduct that is dangerous to a claimant, or failing to meet continuing education requirements. Or Laws 1987, ch 884, 27. For relevant statutory text, *see supra* note 3. The text of those changes indicates that the legislature desired to expand the director's authority to punish health care practitioners for providing **<320 Or 184/185>** medical treatment that is unlawful, dangerous, or in violation of professional standards in the ways described in ORS 656.327(1)(a) and ORS 656.254(3)(a)-(d), and to protect claimants and insurers from having to pay for such medical treatment.

The legislative history sheds light on the legislature's intention in adopting House Bill 2900. On June 10, 1987, the Senate Committee on Labor discussed a version of the bill known as "HB 2900A-9," according to the committee's minutes. At the time, the bill contained the following passage in the section that now comprises ORS 656.327(2):

> "Within 10 working days of receiving the findings of the medical panel, the director shall issue an order based upon the findings of the medical panel. *If the worker, insurer or self-insured employer is dissatisfied with that order, the dissatisfied party may request a hearing on the order.*" (Emphasis added.)

The committee's minutes indicate that Senator Bill Bradbury asked Dr. Frank Russell of the Workers' Compensation Department whether the medical service provider could appeal the director's ruling. The committee's minutes show that the following discussion occurred:

> "DR. RUSSELL said that is consistent with current law. If treatment is denied by an insurer, the doctor can ask for a hearing.
>
> "SENATOR BRADBURY stated we are not talking only about denying treatment. We are talking about coming up with a finding that someone has done something that is improper and a part of the order might be a fine of $1,000. He asked if the doctor could appeal that.

> "MOTION: CHAIRMAN HILL moved that on page 42, in line 20, insert 'or provider of medical treatment' or similar language to allow an appeal by the doctor." Minutes, Senate Committee on Labor (HB 2900A-9), June 10, 1987, p 20.

The committee subsequently adopted the chairman's motion and added the phrase "medical service provider" to the seventh sentence of what later became ORS 656.327(2).

At the same meeting, a discussion occurred about whether the medical service provider's request for a hearing about a finding of inappropriate treatment should proceed **<320 Or 185/186>** under the Administrative Procedures Act (APA), ORS 183.310 to 183.550, or instead should be submitted to the director. According to the committee's minutes, Dr. Russell said in response that

> "under this procedure all the director's order is going to say is stop this treatment or don't pay for this treatment any more. If the director wanted to go after the doctor, he would go after him under the APA in a separate proceeding. He added the sole purpose of this section is to stop inappropriate treatment." Minutes, Senate Committee on Labor (HB 2900A-9), June 10, 1987, p 21.

It appears from the legislative history that the committee added phrases to the bill to permit a medical service provider to request a hearing, because it believed that an adverse finding by the director would indicate, as Senator Bradbury stated, that the provider "has done something that is improper," and the finding might result in a fine of $1,000 against the provider. Senator Bradbury's statement can be read quite easily to refer to a medical service provider's actual commencement and performance of inappropriate medical treatment techniques. Such treatment harms the worker's interest in sound medical treatment and the insurer's interest in paying for treatment only if it is medically appropriate. In contrast, the potential harm to those interests from a mere recommendation for future medical treatment is a matter of speculation because, at that stage, the insurer is not paying for and the worker has not received the recommended medical service.

Dr. Russell's description of the content of the director's order supports the same inference. He indicated that a director's order would tell the doctor to "*stop* this treatment" or would tell, we assume, the insurer that it should not "pay for this treatment *any more.*" (Emphasis added.) Those comments, and his final statement that the section was intended to "stop inappropriate treatment," suggest that the bill was meant to authorize review of treatment that at least is at the stage of actual application or delivery of medical treatment techniques. Given Dr. Russell's description, it would be illogical to conceive of director review as a process that would lead to an order telling the insurer not to "pay for this treatment any more" when the service provider has only recommended, **<320 Or 186/187>** and has not actually commenced performing, the medical service.

Insurer relies on statements made by Ed Redman on May 3, 1990, during a special session of the legislature that adopted several amendments to the Workers' Compensation Law. Or Laws 1990 (Spec Sess) ch 2. Mr. Redman was a member of the Governor's Workers' Compensation Labor Management Advisory Committee that developed the amendments adopted at the special session. Mr. Redman made the following statements to the Interim Special Committee on Workers' Compensation about ORS 656.327(1)(a):

> "Under this section the director will have authority in decisions in regards to medical issues. So if there's an issue of excessive, inappropriate or ineffectual medical treatment, the appeal would go to the medical director. And the medical director's staff or panel that he wishes to have and his staff would make the decision. The intent with this section is to move from the litigation process, with appeals and referees, the question of medical treatment being appropriate, unnecessary or whatever. And decisions then would be made by, again, physicians rather than referees according to the appropriateness of that treatment. An example may be the physician recommends that this worker buy a bicycle for physical therapy and the insurance carrier says no we won't buy the bicycle. Then that would be appealed to the medical director and the medical director's staff under DIF would make the decision whether that was appropriate or not appropriate." Tape Recording, Minutes, Interim Special Committee on Workers' Compensation (SB 1197), statement of Ed Redmond, May 3, 1990, Tape 3, Side A at 65.

According to insurer, Mr. Redman's example about a doctor recommending a bicycle purchase shows that ORS 656.327(1)(a) extends director review authority to recommended medical treatment. It also argues that ORS 656.704(3) was amended in 1990 to give the director authority over disputes regarding medical treatment.

Mr. Redman's testimony regarding the meaning of ORS 656.327(1)(a) and 656.704(3) does not assist us in determining the issue posed in this case. The 1990 amendment to ORS 656.704(3) added the following italicized clause to the last sentence of the section:

> **320 Or 188>** "However, such matters do not include any proceeding for resolving *a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter.*" Or Laws 1990, ch 2, 37 (emphasis added).

That clause does not state what constitutes a dispute regarding medical treatment; instead, the clause requires us to look elsewhere in ORS chapter 656 for that information.

The amendments to ORS 656.327 enacted in 1990 made no change in the scope of medical treatment disputes to which the statute applies. Instead, the legislature altered several of the procedures governing medical treatment review. Or Laws 1990 (Spec Sess), ch 2, 26. None of those changes affected the wording in ORS 656.327(1)(a) adopted in 1987, which we have discussed above, that describes the types of disputes subject to review. Mr. Redman's comments in 1990 shed no light on the legislature's purpose in adopting *in 1987* the language in ORS 656.327(1) that identifies the medical treatment disputes subject to review under that statute.

The legislative history supports what we have described as the most plausible reading of the text and context of ORS 656.327(1). Under our analysis, assuming that the parties and the director comply with any statutory prerequisites to review, the director's review authority under ORS 656.327(1) commences when the medical service provider commences delivery of actual medical treatment to the worker, and the worker is receiving the treatment. Because insurer sought director review of a recommendation for future treatment, the director was not authorized to engage in review under ORS 656.327(1). Accordingly, the matters that ORS 656.704(3) excludes from the Board's authority do not include a request to authorize payment for future medical treatment. For those reasons, the Board was authorized to consider claimant's request for a hearing regarding proposed medical treatment and erred in concluding that it had no jurisdiction over it.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for reconsideration.

Cite as 320 Or 189 (1994) September 29, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of James E. Niccum, Claimant.

JAMES E. **NICCUM**, Respondent on Review,
v.
SOUTHCOAST LUMBER CO. and SAIF CORPORATION, Petitioners on Review.
(WCB 90-17616; CA A73922; SC S40768)

In Banc
On review from the Court of Appeals.*
Argued and submitted May 10, 1994.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for petitioners on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Edward J. Harri, of Malagon, Moore, Johnson, Jensen & Correll, Eugene, argued the cause and filed the response for respondent on review.

Kevin Keaney, of Pozzi, Wilson & Atchison, Portland, filed a brief on behalf of amici curiae Oregon Trial Lawyers' Association and Oregon Workers' Compensation Attorneys.

DURHAM, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for reconsideration consistent with this opinion.

* Judicial review from Workers' Compensation Board, 123 Or App 472, 861 P2d 360 (1993).

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320 Or 191> The issue in this case is whether the Workers' Compensation Board correctly declined to exercise jurisdiction over a claim for future medical treatment. The Board held that, under ORS 656.704(3), a claim for future medical treatment is not a matter concerning a claim that the Board may address, because it is subject to the jurisdiction of the Director of the Department of Insurance and Finance[1] under ORS 656.327(1)(a).

On judicial review, the Court of Appeals reversed, holding that the Board is authorized to resolve a claim for proposed medical treatment and remanded the case for reconsideration. *Niccum v. Southcoast Lumber Co.*, 123 Or App 472, 861 P2d 360 (1993). We allowed review.

This court held in *Martin v. City of Albany*, 320 Or 175, ___ P2d ___ (1994) (1994), that ORS 656.327(1)(a) does not authorize the director to review a dispute over proposed medical treatment. We said:

> "[T]he matters that ORS 656.704(3) excludes from the Board's authority do not include a request to authorize payment for future medical treatment." *Id.* at 188.

The court held that the Board was authorized to address a request for a hearing regarding proposed medical treatment. *Id.*

The Board found that insurer denied a claim for proposed back surgery. The Board erred in concluding that it had no authority to address that claim. *Id.* For that reason, the Court of Appeals correctly reversed the Board's order regarding its jurisdiction.[2]

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for reconsideration consistent with this opinion.

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[1] The Department of Insurance and Finance is now known as the Department of Consumer and Business Services. Or Laws 1993, ch 744, 10.

[2] The Court of Appeals also upheld the Board's conclusion that claimant failed to prove an aggravation of his compensable injury. That issue is not before us on review.

Cite as 320 Or 192 (1994) September 29, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Trina K. Allen, Claimant.

SAIF CORPORATION and ROSE'S RESTAURANT, Respondents on Review,
v.
TRINA K. **ALLEN**, Petitioner on Review.
WCB 91-09837; CA A76538; SC S40951)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 11, 1994; resubmitted June 3, 1994, and reassigned September 6, 1994.

Karen Stolzberg, of Goldberg & Mechanic, Portland, argued the cause and filed the petition and reply brief on behalf of petitioner on review. With her on the petition was Donald M. Hooton, of Schneider, Denorch, Hooton & Galaviz-Stoller, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the responses were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Edward J. Harri, of Malagon, Moore, Johnson, Jensen & Correll, Portland, filed a brief on behalf of amicus curiae Oregon Workers' Compensation Attorneys.

DURHAM, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed, and the case is remanded to the Board for further proceedings.

Graber, J., concurred in part and dissented in part and filed an opinion in which Carson, C.J., and Gillette, J., joined.

*Judicial review from the Workers' Compensation Board, 124 Or App 183, 861 P2d 1018 (1993).

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320 Or 195> This workers' compensation case presents two issues: (1) When the three-judge panel of the Court of Appeals issued a majority opinion, a concurring opinion, and a dissenting opinion, did that court comply with ORS 2.570(4), which requires the "concurrence of two judges * * * to pronounce judgment"? (2) Does ORS 656.386(1), set out below, allow an award of attorney fees when an employer or insurer denies a claim for medical services, but does not deny expressly the compensability of, or its responsibility for, the claimant's injury or condition? We hold: (1) The Court of Appeals complied with ORS 2.570(4); and (2) ORS 656.386(1) allows an award of attorney fees when an employer or insurer denies a claim for medical services, but does not deny expressly the compensability of, or its responsibility for, the claimant's injury or condition.

Claimant injured her back in 1988 while employed at a restaurant. Her employer's insurer, Safeco, accepted her workers' compensation claim for the injury.

In 1989, claimant went to work for a different restaurant, which was insured by SAIF Corporation (SAIF). Thereafter, claimant experienced back pain and neck pain. She filed an aggravation claim with Safeco and a new injury claim with SAIF.

The insurers agreed that claimant's 1989 injury was compensable but disagreed as to responsibility. In 1990, a workers' compensation referee held that Safeco remained responsible for claimant's lower back condition, but that SAIF was responsible for her upper back and neck condition. That order was not appealed.

Meanwhile, claimant had moved to Rhode Island.[1] She submitted various medical bills to SAIF from providers in Rhode Island. SAIF paid some bills but not others.[2]

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[1] By the date of the hearing, claimant was residing in Idaho.

[2] As of March 14, 1991, SAIF had paid a total of $11,448.81 in medical payments on the claim.

Claimant's lawyer wrote a letter to SAIF on March 14, 1991, asking SAIF to pay four unpaid bills that SAIF had **<320 Or 195/196>** received on October 31, 1990.[3] After making adjustments for charges that SAIF contended were excessive under Oregon's workers' compensation medical fee schedule and for charges related to claimant's back condition for which Safeco was responsible, SAIF paid one of the bills on May 1, 1991, and two more on May 3, 1991.[4]

On July 25, 1991, claimant filed a form Request for Hearing and checked the following boxes on the form:

> "REQUEST IS MADE FOR A HEARING CONCERNING ONE OR MORE OF THE REASONS CHECKED BELOW:
>
> "* * * * *
>
> "H X MEDICAL SERVICES ORS 656.245
>
> "* * * * *
>
> "Q X OTHER - EXPLAIN AND CITE ORS[.] Failure to pay medical bills; penalties and attorney fees pursuant to ORS 656.262(10), 656.268, 656.382."

Claimant did not check the boxes relating to "DENIAL," "COMPENSABILITY," or "AGGRAVATION."

SAIF filed a form Response to Request for Hearing. In it, SAIF erroneously stated that "[t]he medical bills have been paid on a timely basis." SAIF also checked the box on the form stating that "[t]here is no known basis for an award of penalties/attorney fees." SAIF did not check the box asserting that a denial should be affirmed or any other box relating to entitlement to compensation.

320 Or 197> In fact, one bill remained unpaid at the time SAIF filed its response. With respect to that bill, SAIF contended that thermography was not reimbursable without prior authorization.[5] Nonetheless, after making adjustments for allegedly excessive charges, SAIF paid the fourth and last medical bill on September 23, 1991.[6]

The referee convened a hearing to determine whether claimant was entitled to an attorney fee under ORS 656.386(1), because her attorney was instrumental in obtaining compensation for claimant before the hearing.[7] The referee awarded claimant an attorney fee under the third sentence of ORS

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[3] The four bills were as follows:

East Bay Medical Thermography	$860.00
RI-Mass MRI, P.C.	850.00
Ocean State Diagnostic Lab.	1,140.00
Toll Gate Chiropractic	427.19

[4] Those payments were as follows:

5/1/91	Toll Gate Chiropractic	$424.09
5/3/91	RI-Mass MRI, P.C.	850.00
5/3/91	Ocean State Diagnostic Lab.	730.03

The propriety of the amounts of those payments is not in issue here.

SAIF also paid other medical bills submitted by claimant after March 14, 1991, which are not at issue here.

[5] OAR 436-10-040(10) and (11) (WCD Administrative Order 1-1990) so provided at the time.

[6] SAIF paid $314.03 to East Bay Medical Thermography. The propriety of the amount of that payment is not in issue here.

[7] Insurer did not argue to this court that convening a hearing to decide entitlement to a fee under the third sentence of ORS 656.386(1) renders that sentence inapplicable. Accordingly, we do not address that question, or the related question of whether the second sentence of ORS 656.386(1), concerning "rejected" cases, authorizes a fee award here.

656.386(1), "for her efforts in obtaining payment of medical bills." The referee found: "It is doubtful that the bills would have been paid if it had not been for claimant's attorney's efforts."

SAIF appealed the attorney fee award to the Workers' Compensation Board (Board). The Board affirmed.

SAIF then sought judicial review. The Court of Appeals reversed the award of attorney fees under ORS 656.386(1). *SAIF v. Allen*, 124 Or App 183, 861 P2d 1018 (1993). The court held 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.'" 124 Or App at 185 (quoting *Shoulders v. SAIF*, 300 Or 606, 611, 716 P2d 751 (1986)). The court explained that, "'where the only compensation issue on appeal is the amount of compensation or the extent of disability[,] * * * ORS 656.386(1) is not the applicable attorney fee statute.'" *Id.* at 186 (quoting *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988)).

Judge De Muniz concurred, because, in his view, "the Supreme Court has indicated that an insurer's failure to **<320 Or 197/198>** timely respond to a claim for compensation may not be construed as a *de facto* denial." *Id.* at 187. He also said:

> "[T]he Supreme Court has indicated that '[a]n insurer's failure to respond to a claim [as required by ORS 656.262(6)] is neither acceptance [n]or denial.' *Johnson v. Spectra Physics*, 303 Or 49, 58, 733 P2d 1367 (1987). The issue in that case was whether an insurer's inaction could be construed as *acceptance* of a claim. The conclusion that inaction does not constitute *denial* is therefore *dictum*. I question whether the Supreme Court really intended claimants to languish while insurers failed to obey the law that requires them to accept or deny claims in a timely fashion." *Id.* at 189 (emphasis in original).

He also said:

> "In my view, an insurer's failure to timely accept or deny a claim ought to be considered a denial, and that should entitle the claimant to attorney fees under ORS 656.386(1) * * *." *Id.* at 187.

Judge Rossman dissented. He asserted that ORS 656.386(1) provides for insurer-paid attorney fees whenever the lawyer is instrumental in obtaining compensation. *Id.* at 189-90.

Claimant petitioned for review. We allowed the petition and reverse the decision of the Court of Appeals.

Claimant's first contention is that the majority opinion and the concurring opinion in the Court of Appeals do not, taken together, satisfy ORS 2.570(4). That statute provides, in part:

> "The presence of three judges is necessary to transact business in any department [of the Court of Appeals], except such business as may be transacted in chambers by any judge. The concurrence of two judges is necessary to pronounce judgment."

In interpreting a statute, the court's task is to determine the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993). The starting points in that determination are the text and context of the statute; the latter includes related statutes on the same subject. Words of common usage typically should be given their plain, natural, and ordinary meaning. *Ibid.*

320 Or 199> The text of ORS 2.570(4) suggests that "concurrence" is required only as to the result reached in a case and not as to the reasoning leading to that result, because it describes the limited purpose for which "concurrence" is required: it is "necessary to pronounce judgment." The term "concurrence" is not defined in the pertinent statutes. "Concurrence" generally means "agreement or union in action"; "agreement in opinion: union in design"; "CONSENT." Webster's Third New International Dictionary 472 (unabridged ed 1993). *See also* Black's Law Dictionary 291 (6th ed 1990) (same). The term "concurrent" is defined, in part, as "marked by accord, agreement, harmony, or similarity in *effect* or tendency." Webster's, *supra*, at 472 (emphasis added). Those ordinary meanings of "concurrence" support the inference stated above.

The context of the provision -- another subsection of the same statute relating to operation of the Court of Appeals -- also supports that inference. ORS 2.570(6) provides, in part:

> "When the [C]ourt [of Appeals] sits in banc, the *concurrence* of a majority of the judges participating is necessary to pronounce judgment, but if the judges participating are equally divided *in their view as to the judgment to be given*, the judgment appealed from shall be affirmed." (Emphasis added.)

In that sentence, the word "concurrence" and the phrase "view as to the judgment to be given" are used interchangeably. In turn, the "judgment" of the Court of Appeals is the final determination of that court as to the rights and obligations of the parties -- that is, the result. *Cf.* ORCP 67 A (as used in the rules of civil procedure, a judgment is "the final determination of the rights of the parties in an action").

We conclude that ORS 2.570(4) requires only that two judges of a three-judge panel of the Court of Appeals concur in, that is, agree to, the result. Agreement as to the reasons leading to that result is not required.

Here, two judges agreed to the result, that is, concurred in the judgment. That being so, the Court of Appeals complied with ORS 2.570(4).

320 Or 200> We turn next to the parties' dispute concerning ORS 656.386(1), the statute under which claimant seeks fees in this case. In workers' compensation cases, an award of attorney fees can be made only pursuant to statutory authorization. *Forney v. Western States Plywood*, 297 Or 628, 632, 686 P2d 1027 (1984); *SAIF v. Curry*, 297 Or 504, 510-11, 686 P2d 363 (1984).

ORS 656.386(1) provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Again, in interpreting a statute, the court's task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 610. The best evidence of the legislature's intent is the text of the statute. *Id.* at 610-11. Also, at the first level of analysis, the court considers the context of the statutory provision at issue, including other provisions of the same statute and other statutes relating to the same subject. *Ibid.* If the intent of the legislature is not clear from the text and context, the court considers the legislative history of the statute. *Id.* at 611-12.

Claimant, the referee, and the Board relied on the third sentence of ORS 656.386(1) -- providing for fees when no hearing is held -- to support the fee award in this case. The Legislative Assembly added that sentence to the statute in 1991. Or Laws 1991, ch 312, 1. This court has not previously construed that sentence.[8]

320 Or 201> We first analyze the text of the relevant statutes. The third sentence of ORS 686.386(1) requires an attorney fee award "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held." The parties assume that the right to fees created by that sentence is predicated on the existence of a "claim for compensation," which is a phrase that appears in the statute's first sentence. We agree. The term "claimant" in the third sentence of ORS 656.386(1) indicates that a "claim" is a prerequisite to the recovery of a fee award. ORS 656.005(6) provides:

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[8] We take note of an issue regarding the third sentence of ORS 656.386(1) that is not before us. In their arguments, the parties assume that the third sentence requires a "denial" of a compensation claim by the insurer. Unlike the first two sentences of the statute, the third sentence does not expressly refer to denial or rejection of a claim. In accordance with the arguments framed by the parties, we assume but do not decide that a denial of a claim for compensation is a predicate for an attorney fee award under the third sentence of ORS 656.386(1).

> "'Claim' means *a written request* for compensation from a subject worker or someone on the worker's behalf, *or any compensable injury* of which a subject employer has notice or knowledge." (Emphasis added.)

ORS 656.005(8) provides:

> "'Compensation' includes *all benefits, including medical services,* provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." (Emphasis added.)

The term "claim" is defined in the disjunctive to refer to *either* "a written request for compensation," which includes a request for medical services, ORS 656.005(8), *or* "any compensable injury." The text indicates that the phrase "claim for compensation" refers equally to a written request for medical services and to any compensable injury of which an employer has notice or knowledge.

Insurer makes two arguments in support of its view that the phrase "denying the claim for compensation" in the first sentence refers to denial of a condition or injury, but not to denial of a written request for medical services. First, it claims that the use of the article "the" in the phrase "*the* claim for compensation" is a reference to the sentence's introductory phrase, "[i]n all cases involving accidental injuries." Insurer argues that the article "the" was intended to indicate that *the* claim that the insurer denies must concern the compensability of an injury. Claimant responds that **<320 Or 201/202>** insurer's argument ignores the fact that "cases involving accidental injuries," ORS 656.386(1), commonly involve *both* kinds of claims listed in the definition of "claim" in ORS 656.005(6). We agree with that proposition. She also argues that insurer's argument is not supported by the legislative history behind the insertion of the article "the" in ORS 656.386(1).

Nothing in the text or context of ORS 656.386(1) explains why the article "the" appears in the phrase under consideration. Because the intention of the legislature in using the article "the" in that phrase is not clear, we resort to the legislative history behind that word. *PGE v. Bureau of Labor and Industries, supra,* 317 Or at 611. Prior to 1981, ORS 656.386(1) referred to "his claim for compensation." In 1981, the legislature changed that phrasing to the present form in an effort to employ gender neutral terminology. Or Laws 1981, ch 854, 25. We find no evidence, and the parties offer none, to suggest that the legislature used the article "the" in this context to exclude from the fee statute any claim that is a "claim for compensation," within the statutory definitions of those terms.

Insurer also argues that other statutes recognize the distinction between a dispute over the compensability of an injury and one over the level of benefits owed on a compensable injury. It cites ORS 656.245(1)(a)[9] and argues that a denial of a claim for medical services may, but need not, include a dispute over the compensability of the injury.

The distinction between a dispute over the compensability of an injury or condition and a dispute over the amount of a claimant's benefits is a familiar one. However, we fail to see how the existence of that distinction supports insurer's argument. The legislature has shown that it can draft statutes to address the denial of particular kinds of claims for compensation when that is its intention. For example, ORS 656.245(2) provides:

> **320 Or 203>** "When the time for submitting a claim under ORS 656.273 has expired, any *claim for medical services* referred to in this section shall be submitted to the insurer or self-insured employer. If the *claim for medical services* is denied, the worker may submit to the board a request for hearing pursuant to ORS 656.283. In the event the worker cannot locate the insurer or self-insured employer, if the worker does not know who the insurer or self-insured employer is, or if the insurer or self-insured employer has ceased to exist, the claim shall be submitted to the director." (Emphasis added.)

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[9] ORS 656.245(1)(a) provides:

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability."

The legislature made no similar effort to confine ORS 656.386(1) to claims in which the insurer or employer disputes the compensability of an injury or condition. We assume that the legislature's choice of terminology in the fee statute was purposeful. That assumption is particularly relevant here because, in the fee statute, the legislature used terms that it specially defined in ORS 656.005(6) and (8).

We are bound to follow the legislature's special definitions of terms used in the Workers' Compensation Law. ORS 656.003 provides:

> "Except where the context otherwise requires, the definitions given in this chapter govern its construction."

In *Astleford v. SAIF*, 319 Or 225, 233, 874 P2d 1329 (1994), the court held that ORS 656.003 calls for use of the definitions specified in ORS chapter 656 unless

> "the context -- including the structure and purpose of the workers' compensation scheme as a whole -- demonstrates that the use of that given definition would be inappropriate, because the result of such use would conflict with one or more aspects of that structure or purpose."

Applying the *Astleford* standard, we finding nothing in the context of ORS 656.386(1) that requires that we apply definitions of the terms "claim" and "compensation" that are different than those specified by ORS 656.005(6) and (8). Insurer's argument amounts to a request that we judicially nullify one-half of the definition of "claim" in ORS 656.005(6). We cannot do that. Under those definitions, a claim for medical benefits is a "claim for compensation" under ORS 656.386(1).[10]

320 Or 204> Insurer argues that claimant's reading of the statute renders ORS 656.386(2) superfluous. That statute provides:

> "In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382."

We disagree. ORS 656.386(2) would still control the payment of attorney fees in cases in which the referee awards additional compensation for permanent partial disability under ORS 656.214 and 656.216. *See* OAR 438-15-040(1). We do not purport to list all potential cases in which ORS 656.386(2) would control payment of fees.[11] We note only that the example that we cite establishes that claimant's reading of ORS 656.386(1) does not render ORS 656.386(2) superfluous.

Insurer also argues that this court's cases have limited the phrase "denying the claim for compensation" in ORS 656.386(1) to disputes over the compensability of an injury or condition and have excluded disputes over the amount of benefits. Claimant disagrees and argues that, even under the cases on which insurer relies, this claim qualifies for a fee award under ORS 656.386(1). Because the latter assertion, if correct, would dispose of insurer's argument, we address it first. In doing so, we are mindful that our authoritative interpretations of a statute implicate the rule of *stare decisis* and become a part of the statute as if written into it at the time of enactment. *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992). We also are aware that this court has declined to apply the doctrine of *stare decisis* to *dictum* in earlier statutory construction cases. *See Cutright v. Weyerhaeuser Co.*, 299 Or 290, 301, 702 P2d 403 (1985) (court declined to rely on *dictum* that was a "questionable pronouncement" in an earlier case about the meaning of a repealed workers' compensation statute); *Safeway Stores v.* <320 Or 204/205> *State Bd. of Agriculture*, 198 Or 43, 81, 255 P2d 564 (1953) (dictum in prior cases construing a statute is "not within the doctrine of *stare decisis*").

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[10] The dissent refuses to adhere to the legislature's definition of "claim," ORS 656.005(6), and that misstep undermines its analysis of the text and context of ORS 656.386(1).

[11] The Board has adopted rules to govern payment of attorney fees out of compensation in cases that are subject to ORS 656.386(2). *See* OAR 438-15-045 (extent of temporary disability); OAR 438-15-050 (disputed claim settlement); OAR 438-15-052 (claim disposition agreement); OAR 438-15-055(1) (extent of temporary or permanent disability at the Board level); and OAR 438-15-080 (attorney is instrumental in obtaining increased compensation in an own-motion case).

Several cases cited by insurer do not address or decide the issue whether a denied claim for medical services, unaccompanied by a challenge to the compensability of the injury or condition, is a denied claim for compensation under ORS 656.386(1). *Peterson v. Compensation Dept.*, 257 Or 369, 477 P2d 216 (1971), held that the claimant was not entitled to fees, because he had not prevailed over the employer's denial. Instead, he had won only the right to a hearing on his claim. In *Cavins v. SAIF*, 272 Or 162, 536 P2d 426 (1975), the insurer denied a claim for medical services on the ground that it was unrelated to work. The court held that a medical services claim was a "claim for compensation" within the meaning of ORS 656.386(1) and that employer's assertion that the services were unrelated to a work injury was a denial that fell within the ambit of the statute. *Ohlig v. FMC Marine & Rail Equipment*, 291 Or 586, 633 P2d 1279 (1981), followed *Cavins* in holding that a lawyer's request for disability and medical services for a client's back condition was a claim for compensation and that the insurer's contention that the back condition was not caused by an injury at work was a denial of a claim for compensation under ORS 656.386(1).

Insurer cites *Shoulders v. SAIF, supra*, which held that the claimant was not entitled to fees under ORS 656.386(1), because the insurer, not the claimant, initiated review by the Board from an order accepting the claim. The court said that the first sentence of ORS 656.386(1)

> "creates three prerequisites for attorney fees:
>
> "1. Claimant must initiate the appeal, because neither an insurer nor an employer would appeal from an order or decision denying the claim for compensation;
>
> "2. The decision must be from an order or decision denying, rather than allowing, the claim for compensation; and
>
> "3. Claimant must finally prevail on the issue of compensation.
>
> **320 Or 206>** "* * * * *
>
> "[T]he claimant must initiate the appeal and prevail on the *compensability issue.*" 300 Or at 611-12 (emphasis added).

Insurer argues that the emphasized phrase means that the "claim for compensation" must concern the compensability of the claimant's condition rather than a claim for benefits. We disagree, because it appears that the emphasized phrase was an attempt to paraphrase the third prerequisite set forth above. None of the listed prerequisites is inconsistent with the Board's fee award here. We conclude that *Shoulders v. SAIF* does not aid insurer.

Insurer draws our attention to the following statement in *Forney v. Western States Plywood, supra*:

> "Claimant's only claim was for the amount of compensation due on her aggravation claim. *Where responsibility is not an issue and the only question is the amount of compensation due, ordinarily attorney fees are not authorized under ORS 656.386(1) and can only be recoverable from the award under ORS 656.382(2).*" 297 Or at 632 (emphasis added).[12]

Insurer also relies on this statement in *Short v. SAIF, supra*, 305 Or at 545:

> "ORS 656.386(1) provides for attorney fees on review of denied claims. The claimant did not appeal to the board or to the Court of Appeals from a decision denying her claim. Both the referee and the board concluded that claimant's condition was

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[12] In *Forney v. Western States Plywood*, the court held that ORS 656.386(1) was inapplicable, because the Board order from which the claimant had appealed had *awarded* full compensation, not denied it. We are unable to discern any connection between the quoted statement and the court's holding. The statement is unaccompanied by any citation of authority, or any consideration of the statutory definitions of "claim" or "compensation" in ORS 656.005(6) and (8).

compensable. *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* and the ORS 656.388(2) route to the circuit court is not available." (Emphasis added.)[13]

320 Or 207> After analyzing the statements in *Forney* and *Short*, on which insurer relies, we conclude that, notwithstanding our concerns about whether they are correct, they are inapplicable here. They purport to apply "[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." *Short v. SAIF, supra*, 305 Or at 545. As discussed below, we conclude that insurer's conduct was a claim denial and that the denial did not confine the issue to the amount of compensation or extent of disability. As a result, the cases on which insurer relies do not render ORS 656.386(1) inapplicable to this claim.

We turn to the Board's conclusion that, on this record, insurer's response to the claim was a denial. Insurer argues that whether it accepted or denied a claim is a question of fact and that its conduct here is not a denial, *de facto* or otherwise.

ORS 656.262(6) provides, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim."

The Board has adopted OAR 436-60-140(3), which restates the substance of the first sentence of ORS 656.262(6). The rule provides:

> "The insurer shall give the claimant written notice of acceptance or denial of a claim within ninety (90) days of the employer's notice or knowledge of a claim."

Insurer did not give the notice required by the statute and rule. Instead, it paid some bills, but not others. When claimant requested a hearing on the unpaid bills, insurer **<320 Or 207/208>** responded in writing that the "medical bills have been paid on a timely basis." That statement was not correct. The Board concluded that insurer had denied the claim:

> "SAIF contends, on review, that this case involves untimely processing, rather than a denial or a 'de facto' denial of medical services. However, we find that at least one of claimant's medical services claims was in 'de facto' denied status at the time claimant requested a hearing, as SAIF had not accepted or denied the claim within 90 days of notice or knowledge of the claim. ORS 656.262(6). Moreover, SAIF had previously paid several of claimant's medical services bills but we find no indication in the record that SAIF intended to pay claimant's last bill. Rather, SAIF's August 30, 1991 response to claimant's request for hearing stated that claimant's 'medical bills have been paid on a timely basis.'"

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[13] The emphasized portion of the last quoted sentence in *Short v. SAIF* is similar to the statement in *Forney v. Western States Plywood*, discussed above. The clause in question bears no relationship to the court's holding in *Short v. SAIF* that ORS 656.386(1) was inapplicable, because the Board had granted, not denied, the claim. The court did not analyze the statutory definition of "claim," ORS 656.005(6), or any words in ORS 656.386(1). As authority for the statement, the court listed three decisions of this court, *Shoulders, supra*, and a "*cf.*" citation to *Ohlig* and *Cavins, supra*. As discussed above, none of those decisions is authority for the statement. The court also cited three decisions of the Court of Appeals, none of which was reviewed by this court. Finally, the court cited the legislature's *rejection* of a bill in 1983 that would have authorized a fee award if a claimant obtained an increase in the extent of permanent disability. *Short v. SAIF, supra*, 305 Or at 547 n 4. The legislature's rejection of a proposed statutory amendment sheds no light on the legislative intention behind the original enactment. The statement, if taken in the sense advocated by insurer, would result in the excision of one-half of the definition of "claim," ORS 656.005(6) in the context of ORS 656.386(1). The court cited no authority to support that result.

The Board's determination that insurer's response to the claim is a denial within the meaning of ORS 656.262(6) is a conclusion of law, not a finding of fact. Accordingly, we review the Board's conclusion for error of law.[14]

320 Or 209> No statute or rule cited by the parties or discovered by us defines "denial" for purposes of ORS 656.262(6). In reviewing the Board's construction and application of the term "denial," we follow the methodology described in *Springfield Education Assn. v. School Dist.*, 290 Or 217, 233, 621 P2d 547 (1980). *See England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993) (applying *Springfield* analysis to statutory term "earning capacity"); *Tee v. Albertson's, Inc.*, 314 Or 633, 637, 842 P2d 374 (1992) (applying *Springfield* analysis to statutory term "gainful occupation").

In *Springfield*, this court recognized three categories of statutory terms: exact terms, inexact terms, and delegative terms.[15] The term "denial" in ORS 656.262(6) is an inexact term, which means that "the legislature has expressed its meaning completely, but that meaning remains to be spelled out in the agency's rule or order." *England v. Thunderbird, supra*, 315 Or at 638. *England v. Thunderbird* also states:

> "An inexact term gives the agency interpretive but not legislative responsibility. *See Springfield Education Assn. v. School Dist., supra*, 290 Or at 233 (so holding for terms 'employment relations' and 'conditions of employment'). With respect to an inexact term, the role of the court is to determine whether the agency 'erroneously interpreted a provision of law,' ORS 183.482(8)(a), and the ultimate interpretive responsibility lies with the court in its role as the arbiter of questions of law. *Springfield Education Assn. v. School Dist., supra*, 290 Or at 234." *Id.*

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[14] ORS 183.482(7) and (8) provide:

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. In the case of disputed allegations of irregularities in procedure before the agency not shown in the record which, if proved, would warrant reversal or remand, the Court of Appeals may refer the allegations to a Master appointed by the court to take evidence and make findings of fact upon them. The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

[15] *Springfield* describes the three classes of statutory terms as follows:

"1.) Terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and judicial review for substantial evidence;

"2.) Inexact terms which require agency interpretation and judicial review for consistency with legislative policy; and

"3.) Terms of delegation which require legislative policy determination by the agency and judicial review of whether that policy is within the delegation." 290 Or at 223.

In addressing whether the Board erroneously interpreted ORS 656.262(6), the dispositive question of law on review, under ORS 183.482(8)(a), is

> "whether the agency action is within the legislative policy which inheres in the statutory term. An agency interpretation may be given an appropriate degree of assumptive **<320 Or 209/210>** validity if the agency was involved in the legislative process or if we infer that it has expertise based upon qualifications of its personnel or because of its experience in the application of the statute to varying facts. Judicial deference, however, is not automatic or unreasoning. If a statute must be interpreted to determine its applicability to the facts of a contested case, then, it is necessary for the agency to express in its order, to the degree appropriate to the magnitude or complexity of the contested case, its reasoning demonstrating the tendency of the order to advance the policy embodied in the words of the statute. Explicit reasoning will enable the court on judicial review to give an appropriate degree of credence to the agency interpretation." *Springfield Education Assn. v. School Dist., supra,* 290 Or at 227-28.

We must interpret ORS 656.262(6) in order to decide whether the Board's action "coincides with the legislative policy which inheres in the meaning of the statute." *Id.* at 228.

In construing the statute, the legislature's words are the best evidence of its intention. Ordinarily, we give words of common usage their plain, natural, and ordinary meaning. *PGE v. Bureau of Labor and Industries, supra,* 317 Or at 611. The dictionary defines the word "denial" as follows:

> "1. refusal to grant, assent to, or sanction: rejection of something requested, claimed, or felt to be due * * * 2a. refusal to admit the truth of a statement, charge, or imputation * * *." Webster's Third New International Dictionary 602 (unabridged 1993).

We also consider, at the first level of analysis, the context of the statutory provision at issue, including other provisions of the same statute. ORS 656.262(1), (2), (8), (9), and (10)(a) provide:

> "(1) Processing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. All employers shall assist their insurers in processing claims as required in this chapter.
>
> "(2) 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.
>
> "* * * * *
>
> **320 Or 211>** "(8) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319.[16]
>
> "(9) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof.

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[16] To implement ORS 656.262(8), the Board has adopted OAR 436-60-140(6), which provides:

"The notice of denial shall comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law and shall:

"(a) Specify the factual and legal reasons for the denial; and

"(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283."

> "(10)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. The director's action and review thereof shall be subject to ORS 183.310 to 183.550 and such other procedural rules as the director may prescribe."

In the text of ORS 656.262(6), the legislature has afforded two options to an insurer who receives notice or knowledge of a claim for compensation. The insurer may accept or deny the claim. The text does not provide the insurer with the option to take no position on acceptance or **<320 Or 211/212>** denial of the claim. The text supports the Board's conclusion that insurer's conduct was a denial.

The context of ORS 656.262(6) also supports the Board's result. ORS 656.262(1) makes the insurer or self-insured employer responsible for "[p]rocessing of claims and providing compensation for a worker." ORS 656.262(2) obligates the insurer or employer to pay compensation due under the law "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.*" (Emphasis added.) ORS 656.262(6) promotes certainty and promptness[17] in the execution of those responsibilities by requiring the insurer to provide

> "[w]ritten notice of acceptance or denial of the claim * * * within 90 days after the employer has notice or knowledge of the claim."

ORS 656.262(8) requires the insurer to include in the written notice the reason for the denial and information about the claimant's hearing rights under ORS 656.283.[18] The insurer **<320 Or 212/213>**

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[17] ORS 656.012(2) provides, in part:

"In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

"(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

"(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;

"(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable[.]"

[18] ORS 656.283 provides, as material:

"(1) Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim.

"(2) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter. Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time, unless the worker's dissatisfaction is otherwise resolved. The decision of the director may be modified only if it:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

"(3) 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.

"(4) The board shall refer the request for hearing to a referee for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party."

must give the notice of denial to the claimant and mail copies to the employer and the Director of the Department of Consumer and Business Services.

The notice of a denial is a key procedural component of the claim adjudication system. ORS 656.262(8) entitles a claimant who receives notice of a denial to request a hearing under ORS 656.283. The claimant or the director must request a hearing within the time limits specified in ORS 656.319.[19] Because the notice of denial includes the insurer's reasons for the denial, it enables the claimant, the Board, and the director to determine the scope of any disputed issues and the proper forum for resolution of those issues. For example, an insurer's assertion that the underlying injury or condition is not related to work would ordinarily lead to a hearing under ORS 656.283(1). A denial of vocational assistance requires the dissatisfied claimant to apply to the director for administrative review **<320 Or 213/214>** under ORS 656.283(2).[20] A denial that raises an issue of responsibility covered by ORS 656.307(1)[21] requires the director to designate who shall pay the claim. In these examples, and probably others, compliance by insurers with the statutory duty to provide timely written notice of a denial furnishes important information to affected parties, the Board, and director that permits them to guide the dispute to the proper decision-making body within the compensation system, narrows the issues on which the parties must prepare for litigation, and expedites disposition of claims through hearing or settlement. The legislature underscored the importance of compliance by making an insurer liable to the worker for an additional amount of money if the insurer "unreasonably delays acceptance or denial of a claim." ORS 656.262(10)(a).

Insurer's argument, that it merely was late in paying bills, disregards its statutory obligation to furnish written notice of acceptance or denial of a claim within 90 days. ORS 656.262(6). That argument also ignores the importance to the claim adjudication process of an insurer's compliance with that obligation. Without question, the Board has significant experience in applying procedural statutes, such as ORS 656.262(6), to claim proceedings before it, and knows the deleterious effects that can result to the administrative scheme when an insurer disregards its duty to timely accept or deny a claim.

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[19] ORS 656.319 provides, as material:

"(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial.

"(2) Notwithstanding subsection (1) of this section, a hearing shall be granted even if a request therefor is filed after the time specified in subsection (1) of this section if the claimant can show lack of mental competency to file the request within that time. The period for filing under this subsection shall not be extended more than five years by lack of mental competency, nor shall it extend in any case longer than one year after the claimant regains mental competency."

[20] The text of ORS 656.283(2) is set forth at note 20, *supra*.

[21] ORS 656.307(1) provides:

"Where there is an issue regarding:

"(a) Which of several subject employers is the true employer of a claimant worker;

"(b) which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

"(d) Joint employment by two or more employers,

the director shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262(4)."

With those considerations in mind, we turn to the Board's conclusion that insurer denied this claim. The Board **<320 Or 214/215>** applied the term "de facto denial" to insurer's failure to accept or deny the claim within 90 days, as required by ORS 656.262(6). The Board's application of the statute coincides with the legislative policy, embodied in the statute, to compel insurers to timely declare whether they accept or deny claims. The Board's construction of the statute tends to advance the legislature's generally expressed policies promoting the prompt delivery of medical benefits and compensation to injured workers, and a fair and just administrative system that reduces litigation and eliminates the adversary nature of compensation proceedings to the greatest extent practicable. ORS 656.012(2)(a)-(c).

The Board also drew attention to insurer's response to the request for a hearing, in which insurer said that claimant's "medical bills have been paid on a timely basis." The Board was entitled to construe that statement as a denial because, in context, it asserted that claimant was not entitled to anything on his claim for unpaid medical bills.

Insurer relies on *Johnson v. Spectra Physics, supra,* but that case does not aid insurer. The issue in Johnson was whether an insurer's notice or knowledge of a condition, coupled with the passage of 60 days, ORS 656.262(6), could serve as an acceptance of the condition under the rule in *Bauman v. SAIF,* 295 Or 788, 790, 670 P2d 1027 (1983). This court held that it could not, because

> "an insurer's silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim. Silence is neutral. One could argue that if an insurer's silence regarding a condition implies anything, it would imply denial, not acceptance." *Johnson v. Spectra Physics, supra,* 303 Or at 55.

That passage is inapplicable here. *Johnson* concerned the requirements for an acceptance to trigger the application of the *Bauman* backup denial rule. It did not concern the requirements for a denial of a claim for compensation, as in this case. For that reason, the statement in *Johnson* about whether an insurer's silence can constitute a denial is *dictum.* We do note that the Board's result here carries the import of this court's last sentence in *Johnson,* quoted above, to its logical conclusion. Furthermore, unlike in *Johnson,* the issue **<320 Or 215/216>** here did not concern only the effect of insurer's silence in response to a claim.

The Board's conclusion that insurer denied the claim is supported by the text and context of ORS 656.262(6) and is consistent with the legislative policy exemplified by that statute, the other statutes cited above that concern claim adjudication, and the legislature's generally expressed objectives for the Workers' Compensation Law. Because the Board's action is within the legislative policy behind ORS 656.262(6), the Board did not err.[22] *Springfield Education Assn. v. School Dist., supra,* 290 Or at 227.

The parties dispute the effect of insurer's denial for purposes of ORS 656.386(1). Insurer argues that it never asserted that it was refusing to pay the medical bills because of a decision not to pay them or *because* it intended to challenge the compensability of claimant's injury. Claimant responds that insurer failed to timely accept or deny the claim, as required by law, and failed to make clear that it was not going to contest the compensability of claimant's injury. She argues that insurer's conduct left it free to contest all aspects of the claim, including the compensability of the injury for which she sought medical services. Insurer acknowledges that a benefit claim is an opportunity for an insurer to deny the injury or condition for which the claimant seeks benefits but argues that, unless the insurer refuses payment on the basis that the condition is not compensable, there is no denial within the meaning of ORS 656.386(1).

We addressed a similar argument from an insurer in the *Ohlig* case and rejected it. In *Ohlig,* the insurer accepted an ankle injury in 1975. Two years later, the claimant's lawyer submitted a request for surgery for a back condition, asserting that it was connected to the 1975 injury. 291 Or at 588-89. A Board administrative rule, OAR 436-83-125, provided, in part:

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[22] We do not hold, as the dissent asserts, that insurer "revoked" its prior acceptance of the injury under ORS 656.262(6). 320 Or at 230 (Graber, J., concurring and dissenting). The dissent's argument results from its flawed premise that the legislature did not intend to apply its definition of "claim," ORS 656.005(6), in ORS 656.262(6). Nothing in the Board's order or this opinion suggests that the procedures in ORS 656.262(6) regarding revocation of acceptance and issuance of a formal denial are involved in this case.

> **320 Or 217>** "Every notice of partial denial shall set forth with particularity the injury or condition for which responsibility is denied and the factual and legal reasons therefor. The notice shall be in the form provided for in [OAR 436-]83-120. Hearing and appeal rights and procedures shall be as provided for claim denials in ORS 656.262(6) and (7), 656.319 and these Rules."

In violation of the rule, the insurer gave no notice of a denial of the back condition and the factual and legal reasons therefor. When the claimant prevailed on the back claim and sought attorney fees under ORS 656.386(1), the insurer asserted that the statute was inapplicable, because it had never denied the back condition in writing and had accepted the ankle condition in writing. This court rejected that argument, and the court's analysis of the effect of the insurer's failure to make clear its reason for denying the back condition is relevant here. This court said:

> "The statutes to which reference is made in the [administrative] rule concern the denial of claims and the procedure for a claimant to contest a denial. The reference to OAR 436-83-120 refers to the Board rule which fleshes out statutory duties of employers who would deny claims.
>
> "The employer here failed to follow the administrative rule despite the fact the worker's lawyer filed a claim for the back condition and the employer refused to accept responsibility for that condition. * * * *Certainly the employer should be in no better position for failure to give the written notice of denial required by the rule than would have been the case had there been compliance."* *Ohlig v. FMC Marine & Rail Equipment, supra,* 291 Or at 597 (emphasis added).

Following that reasoning, we decline to allow insurer to take advantage of its unlawful failure to timely accept or deny the claim. Unless an insurer makes clear that its denial does not dispute the compensability of the injury or condition, the claimant remains subject to a statutory burden to prove that the injury is compensable. ORS 656.266. Late payment of the medical bills did not operate to accept the claim or admit liability. ORS 656.262(9). In the light of the policy underlying ORS 656.262(6), permitting insurer to profit from its ambivalence concerning the *basis* for its refusal to pay the claim would, in the words of this court in *Ohlig*,

> **320 Or 218>** "elevate form over substance and involve the worker's compensation system in semantic gymnastics." *Id.* at 595.

Because compensability was not conceded by insurer's denial here, it remained a contested issue. It follows from the foregoing that insurer's denial did not confine the issue on the claim to the amount of compensation or the extent of disability, rather than the compensability of claimant's injury or condition, within the meaning of the statements quoted above in *Forney v. Western States Plywood* and *SAIF v. Short*. Insurer does not argue that the Board erred in concluding that claimant's counsel was instrumental in obtaining compensation, within the meaning of ORS 656.386(1). We conclude that the lawyer was instrumental in obtaining compensation and overcame a denied claim for compensation, within the meaning of ORS 656.386(1), in doing so.

Finally, insurer contends that the Board erred in awarding a fee under ORS 656.386(1), because insurer's conduct amounts to unreasonable delay in paying compensation, for which claimant's lawyer can receive only one-half of a penalty under ORS 656.262(10), in lieu of an attorney fee. ORS 656.262(10) provides:

> "(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. The director's action and review thereof shall be subject to ORS 183.310 to 183.550 and such other procedural rules as the director may prescribe.

> "(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount described in this subsection, the provision for attorney fees provided in this subsection shall apply in the other proceeding."

320 Or 219> The text of ORS 656.262(10) and 656.386(1) indicates that those statutes address distinct subjects. ORS 656.386(1) requires a reasonable attorney fee award when a claimant prevails over a denial of a claim for compensation, either on judicial or administrative review, or if the lawyer is instrumental in obtaining compensation prior to a hearing. ORS 656.262(10) makes an insurer or self-insured employer liable for a penalty if those parties unreasonably delay or unreasonably refuse to pay compensation, or unreasonably delay acceptance or denial of a claim. If a represented worker seeks a penalty for one of those unreasonable acts, the lawyer receives one-half of the additional penalty "in lieu of an attorney fee." ORS 656.262(10)(a).

The Board awarded a reasonable attorney fee under ORS 656.386(1), because claimant's lawyer was instrumental in obtaining compensation prior to a hearing. Claimant did not seek that fee as a sanction for an unreasonable delay in paying compensation, or an unreasonable delay in acceptance or denial of his claim. It appears, under our examination of the text of the two statutes, that the claim for reasonable attorney fees is unrelated to the phrase "in lieu of an attorney fee" in ORS 656.262(10)(a). Although that reading appears to be the most reasonable construction of the statutes, the legislative intention is not clear. Accordingly, we proceed to an examination of the legislative history behind the two statutes.

The legislature added the third sentence to ORS 656.386(1) in 1991 to permit recovery of a fee where the insurer denies the claim, but agrees to pay compensation prior to hearing. The legislature intended the amendment to reverse the holding of *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *mod* 108 Or App 230, 814 P2d 558 (1991), which ruled that under the former version of ORS 656.386(1), the claimant does not prevail *in* the hearing if the insurer agrees to pay compensation, even on the eve of the hearing. Or Laws 1991, ch 312, 1; *see* Tape Recording, Senate Committee on Labor (SB 540), March 20, 1991, (testimony of Chris Moore) Tape 40, Side A; Tape Recording, Senate Floor Debate, March 27, 1991, (statement of Senator Grattan Kerans) Tape 50, Side A; Tape Recording, House Committee on Labor, May 29, 1991, (remarks of Representative Kevin Mannix) Tape 154, Side B. **<320 Or 219/220>** Nothing in the legislative history behind the 1991 amendment to ORS 656.386(1) suggests that it was linked to the subject of sanctions under ORS 656.262(10)(a) for unreasonable insurer conduct.

The legislature added the words "in lieu of an attorney fee" to ORS 656.262(10)(a) in 1990. Or Laws 1990 (Spec Sess), ch 2, 15. Prior to the amendment, two statutes addressed the problem of an insurer's refusal or resistance to payment of compensation. At that time, ORS 656.382(1) provided:

> "If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney for the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

The other statute was ORS 656.262(10).[23]

As a result of those two statutes, claimants were entitled to both an attorney fee award under ORS 656.382(1) and a sanction under ORS 656.262(10) for similar unreasonable conduct by an insurer. To remedy the seeming overlap of those statutes, the legislature adopted the "in lieu of an attorney fee" wording in ORS 656.262(10)(a) at the recommendation of a task force assembled by the Governor. The following is the only pertinent legislative history for the amendment to ORS 656.262(10)(a) that we have discovered. Annette Talbott, legal counsel to the Joint Interim Special Committee on Workers' Compensation, explained the purpose of the amendment to a joint session of the legislature, as follows:

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[23] Before the 1990 amendment, ORS 656.262(10) provided:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

"This was an issue the Governor's group wanted to clarify, that in cases where there is a penalty, as described in subsection 10, for unreasonable delay or an unreasonable **<320 Or 220/221>** refusal to pay compensation, that the penalty that's spelled out in subsection 10 is the sole--and particularly in regard to the attorney fee--attorney fee which is one half of the additional amount is the sole attorney fee that will be awarded on this type of penalty, even if this issue is combined with other issues at the referee or the Board level." 1990 Joint Special Session, Committee on Workers' Compensation (SB 1197), May 4, 1990, (statement of Annette Talbott) Tape 20, Side B at 40.

After Ms. Talbott spoke, Representative Kevin Mannix made this statement:

"It says that if the worker wants to write a letter to the director to get a penalty, he can get it. If his attorney does it for him, the attorney gets half of the penalty instead of some add on fee. If the attorney throws in the penalty issue along with a bunch of other issues in a request for hearing, that that penalty issue doesn't lead to a separate attorney fee, but that half the penalty is the fee. And that's a policy question. You just answer it the way you think you ought to. And we all have our war stories. But I've seen the piggyback penalty and fee issue where the attorney fee, and, literally, in one of my cases, was $250 and the penalty was $7 to the worker. No other relief to the worker. I had another one that came down last week where the attorney fee was $300 and the penalty was $10.25. And I think that's ridiculous. That's my policy issue." 1990 Joint Special Session, Committee on Workers' Compensation (SB 1197), May 4, 1990, (remarks of Representative Kevin Mannix) Tape 20, Side B at 99.

The most plausible construction of those statements is that the amendment of ORS 656.262(10) was designed to authorize the Board to award a penalty for unreasonable insurer conduct and to prevent the Board from awarding a separate attorney fee for the same unreasonable conduct. The history of the amendment does not indicate that the amendment was intended to nullify Board authority to award attorney fees under statutes that do not address penalties for unreasonable conduct. For example, ORS 656.386(1) requires a fee award if the claimant prevails or obtains benefits on a claim for compensation. It has nothing to do with penalizing unreasonable insurer conduct. We think that such a significant change in the attorney fee scheme would be accompanied by legislative history demonstrating such an **<320 Or 221/222>** intention. However, the testimony regarding the amendment to ORS 656.262(10)(a) does not discuss ORS 656.386(1).

We conclude that the 1990 amendment to ORS 656.262(10) was not intended to prevent the Board from awarding a reasonable attorney fee under ORS 656.386(1). The 1991 amendment to the latter statute authorizes the Board to award a fee if the lawyer is instrumental in obtaining compensation prior to a hearing. A fee award under ORS 656.386(1) is not subject to the "in lieu of an attorney fee" limitation in ORS 656.262(10)(a).

To summarize, the claim for medical services was a "claim for compensation" within the meaning of ORS 656.386(1) and the definitions in ORS 656.005(6) and (8). The Board's conclusion that insurer denied the claim is not erroneous. The denial did not concede that the underlying injury was compensable and, for that reason, the amount of compensation was not the sole issue raised by the denial. Finally, the Board's authority to award a fee under ORS 656.386(1) is not affected by ORS 656.262(10)(a). The Board's order awarding an attorney fee under ORS 656.386(1) was correct. If the Board order effects an inequitable result for insurers who fail to timely pay requests for medical services, that inequity must be corrected by the legislature, not by this court. *Stovall v. Sally Salmon Seafood*, 306 Or 25, 39, 757 P2d 410 (1988); *Forney v. Western States Plywood, supra*, 297 Or at 634.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed, and the case is remanded to the Board for further proceedings.

GRABER, J., concurring in part and dissenting in part.

I concur fully in the majority's resolution of the first issue presented in this workers' compensation case. The Court of Appeals complied with ORS 2.570(4), which requires the "concurrence of two judges * * * to pronounce judgment."

I dissent, however, from the majority's abandonment of established principles of statutory construction in its resolution of the second issue. In my view, ORS 656.386(1) does not allow an award of attorney fees when an employer or <320 **Or 222/223**> insurer pays medical bills late but does not deny the compensability of, or its responsibility for, the claimant's injury or condition.

The starting point is the principle that, in workers' compensation cases, an award of attorney fees can be made only pursuant to statutory authorization. *Forney v. Western States Plywood*, 297 Or 628, 632, 686 P2d 1027 (1984); *SAIF v. Curry*, 297 Or 504, 511, 686 P2d 363 (1984). As this court explained in *Forney*, 297 Or at 632, in holding that no attorney fees could be awarded under the terms of the workers' compensation statute involved:

> "It is fundamental that the legislature provides rights and remedies for workers and employers. This court cannot exceed the legislative limitations *even though an inequity to the employe* or to the employer *might result*. Unless a specific statute authorizes an award of attorney fees to a claimant, this court cannot award them." (Emphasis added.)

Similarly, in *Curry*, 297 Or at 510-11, this court

> "recognize[d] that this result [no fees in the situation presented] is harsh for claimant's attorney in this case. * * * In this instance his work will go uncompensated; however, our ability to award attorney fees in workers' compensation cases is limited to the authority granted by statute. In this case we have no authority and must refuse to make an award."

In the absence of clear legislative authorization, then, no fees are available.

The statute under which claimant seeks fees in this case is ORS 656.386(1), which provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a <320 **Or 223/224**> reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Claimant relies specifically on the third sentence of ORS 656.386(1) -- providing for fees when no hearing is held -- to support the fee award in this case. The Legislative Assembly added that sentence to the statute in 1991. Or Laws 1991, ch 312, 1.

In interpreting a statute, the court seeks to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). At the first level of analysis, the court considers the text and the context of the statutory provision at issue, including other provisions of the same statute and other statutes relating to the same subject. *Id.* at 610-11. If the intent of the legislature is not clear from that inquiry, the court considers the legislative history of the statute. *Id.* at 611-12. Additionally, when this court has construed a statute, that construction is part of the statute as if written therein. *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992).

On appeal and on review, the parties do not dispute that a "decision denying the claim for compensation" is a prerequisite to a claimant's obtaining a fee under the third sentence of ORS 656.386(1). Their arguments focus on the question of what the legislature meant when it used the phrase "decision denying the claim for compensation" in ORS 656.386(1). Claimant contends that failure to pay a medical bill on time is an instance of a "decision denying the claim for compensation," because compensation "includes all benefits, including medical services, provided for a compensable injury," ORS 656.005(8). SAIF asserts that a "decision denying the claim for compensation" in ORS 656.386(1) means

> "a decision by the insurer not to pay compensation on the ground that the *injury or condition* for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation." (Emphasis in original; footnote omitted.)

For the reasons that follow, I agree with SAIF.

First, the text of ORS 656.386(1) itself makes SAIF's interpretation more likely. The statute uses the phrase "denying *the claim for* compensation" (emphasis added), rather than the phrase "denying compensation." Failure or refusal to pay a medical bill for an *accepted* injury or condition denies compensation, by denying the particular amount of benefits sought, but it generally does not deny *the claim for* compensation.[1] Claimant's interpretation of the statute thus reads the phrase "the claim for" out of the statute. By contrast, SAIF's interpretation gives meaning to all words in the statute. *See* ORS 174.010 (in construing a statute, the court is "not to * * * omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all").

Second, the statutory context reinforces SAIF's reading. Several sections of the workers' compensation law differentiate between a claimant's entitlement to compensation (compensability) and the amount of compensation owed for the claim if accepted (benefits). For example, ORS 656.266 provides that "[t]he burden of proving that an injury * * * is compensable *and* of proving the nature and extent of any disability resulting therefrom is upon the worker." (Emphasis added.) Further, ORS 656.262(10)(a)[2] expressly differentiates between unreasonably delaying or unreasonably refusing "to pay compensation" (benefits), on the one hand, and unreasonably delaying "acceptance or denial of a claim" (compensability), on the other.

320 Or 226> Third, this court's prior cases recognized that "denying the claim for compensation" in ORS 656.386(1) means asserting that the injury is not compensable at all. In *Peterson v. Compensation Department*, 257 Or 369, 477 P2d 216 (1970), the insurer denied compensability of the claimant's claim for an injury. A referee upheld the denial, but the Board reversed and remanded the case to the referee for further proceedings relating to the denial. This court held that the claimant was not entitled to a fee at the time of the remand, under ORS 656.386(1), because the claimant had not yet prevailed. *Id.* at 374. In discussing the history and development of the statute, the court said that "the right to an attorney fee [under ORS 656.386(1)] has been and is dependent on establishing the right to compensation after an original rejection of the claim." 257 Or at 375. *See also Cavins v. SAIF*, 272 Or 162, 164-65, 536 P2d 426 (1975) (the claimant was entitled to attorney fees under ORS 656.386(1) when the insurer had denied a request for surgery on the ground that the surgery was not causally related to the accepted injury and thus had denied compensability of the condition for which the claimant sought compensation); *Ohlig v. FMC Marine & Rail Equipment*, 291 Or 586, 595-98, 633 P2d 1279 (1981) (the claimant was entitled to a fee under ORS 656.386(1) for overcoming the employer's "partial denial," when the employer had accepted compensability for an ankle injury but denied liability for a low back condition; denying the claim for compensation relates to a condition for which compensation is claimed); *Forney v. Western States Plywood, supra*, 297 Or at 632 (the claimant could not obtain attorney fees under ORS 656.386(1), because her "only claim was for the amount of compensation due on her aggravation claim," as distinct from "responsibility" for an unaccepted condition); *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988) (this court distinguished between the amount of compensation or the extent of disability, on the one hand,

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[1] The submission of a medical bill concerning an injury or condition that has not already been accepted can constitute the claim for compensation. See ORS 656.005(3) (defining "claim"); ORS 656.262 (providing procedure to process claims); ORS 656.265(2) (notice of accident resulting in an injury need not be in any particular form). Moreover, an insurer or self-insured employer can use a benefit claim as an opportunity to deny the injury or condition for which benefits are sought. *See* ORS 656.262(6) (providing procedure to process claims). In those situations, the submission of a medical bill can give rise to a denial of "the claim for" compensation. Neither of those situations is involved in this case, however.

[2] ORS 656.262(10)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. * * * The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount, in lieu of an attorney fee."

and the question "whether the claimant's condition was caused by an industrial injury," on the other; ORS 656.386(1) does not apply to the former).[3]

320 Or 227> In the aggregate, the text, context, and prior interpretations suggest that a "decision denying the claim for compensation" within the meaning of ORS 656.386(1) is a decision not to pay compensation on the ground that the injury or condition is not compensable or otherwise does not entitle the claimant to compensation.[4] However, because the legislature's intent in that regard is not completely clear after the foregoing inquiry, I also examine the legislative history of the 1991 amendment to the statute.

The 1991 amendment to ORS 656.386(1) was enacted as part of Senate Bill 540. The legislative history of Senate Bill 540 demonstrates that the amendment was enacted for the purpose of overruling *Duane L. Jones*, 42 Van Natta 875 (1990), *aff'd in Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *on reconsideration*, 108 Or App 230, 814 P2d 558 (1991),[5] and for the purpose of authorizing attorney fees when the compensability of a claim for workers' compensation has been denied and the employer or insurer rescinds the denial through the efforts of the claimant's lawyer.

During consideration of Senate Bill 540, a member of the workers' compensation claimants' bar who was the principal witness at the Senate and House hearings testified:

> "[Senate Bill 540] requires that insurers or self-insured employers pay an attorney's fee over and above any compensation when a denial is rescinded prior to the matter going to hearing. As I say, that was the law and that was the practice in workers' compensation until the Workers' Compensation **<320 Or 227/228>** Board issued a case about a year ago called *Duane Jones*. * * * [I]t's my belief that this bill only reverses the *Duane Jones* case." Tape Recording, Senate Committee on Labor, March 20, 1991, Tape 40, Side A.

The same witness made similar comments to the House Committee on Labor, emphasizing that this bill applies when the insurer or self-insured employer "rescinds their denial." Tape Recording, House Committee on Labor, May 27, 1991, Tape 148, Side B. *See also* Tape Recording, House Committee on Labor, May 29, 1991, Tape 154, Side B (statement of Representative Mannix supporting that testimony, that lawyers who "succeed[] in convincing the insurance company that the claim was good before going to hearing would be awarded an attorney fee").

On the floor of the Senate, Senator Kerans stated that "Senate Bill 540 reverses what's known as the *Jones* decision" and permits attorney fees where a lawyer worked "to advance your claim, even though it had been denied by the insurer, if the insurer, even up to the minutes before a hearing was held, reversed field and said, okay, we will no longer resist your claim, but, in fact, accept it." Tape Recording, Senate Floor Debate, March 27, 1991, Tape 50, Side A.

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[3] The only case in which this court arguably took the view that claimant urges on us is *Ellis v. McCall Insulation*, 308 Or 74, 775 P2d 316 (1989). In that case, the insurer stopped paying for the claimant's chiropractic treatments several years after a compensable injury, which the insurer had accepted, on the ground that they were not related to the compensable injury. This court held that the insurer's failure to respond in a timely manner was not an acceptance of responsibility for payment of the bills. In so holding, this court "assume[d] that [claimant's] unpaid chiropractic bills were 'claims' under ORS 656.262(6)." *Id.* at 77 (footnote omitted). That assumption was not a holding, however.

[4] Other bases for denying compensation could include, for example, that the particular employer is not responsible for the compensable injury or that the claim was filed too late.

[5] In *Duane L. Jones*, 42 Van Natta 875 (1990), *aff'd in Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *on reconsideration*, 108 Or App 230, 814 P2d 558 (1991), the Board and the Court of Appeals held that the former version of ORS 656.386(1) "provide[d] no basis for an award of insurer-paid attorney fees to a claimant when the employer withdraws its denial of the claim after the claimant's request for hearing has been filed but before the referee has decided the matter." 108 Or App at 232. The underlying issue in the *Jones* case was *compensability* of the claimant's injury. 107 Or App at 82.

Those statements of legislators and of the principal witness are couched in terms of denial versus acceptance of compensability of the underlying claim. And, the *Jones* case, which Senate Bill 540 was designed to overrule, was a case in which the compensability of the underlying claim had been denied. The legislative history thus confirms what the text, context, and prior interpretations suggest. A "decision denying the claim for compensation" within the meaning of ORS 656.386(1) is a decision not to pay compensation on the ground that the injury or condition is not compensable or otherwise does not entitle the claimant to compensation.

Claimant's final contention is that the failure to pay medical bills, or at least to respond definitively to a written request to pay medical bills, within the time set by statute[6] is **<320 Or 228/229>** a "de facto" denial of the underlying claim for compensation. I disagree.

I note, first, that the legislature has drawn a distinction between *delay* and *denial*. ORS 656.262(10)(a) provides for a penalty when an "insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." If delay in paying compensation were the equivalent of denial of a claim, the two phrases in that statute would be redundant. The statutory context, therefore, weighs against claimant's suggested interpretation of the concept of denying a claim.

Second, and more fundamentally, this claim could not have been denied by silence when claimant submitted the medical bills in question, because the claim already had been accepted. In *Bauman v. SAIF*, 295 Or 788, 790, 670 P2d 1027 (1983), this court held that the version of ORS 656.262(6) then in effect barred an employer from denying a claim that previously had been accepted. *See also Johnson v. Spectra Physics*, 303 Or 49, 58, 733 P2d 1367 (1987) ("An insurer's failure to respond to a claim or one aspect of a claim is neither acceptance nor denial"). ORS 656.262(6) has been amended to provide in part that,

> "if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance *and issue a formal notice of claim denial.*" (Emphasis added.)

Thus, denial of a claim that previously had been accepted requires specific formalities, which did not occur in this case. Mere silence on receipt of a medical bill did not become a denial of the claim.

In this case, SAIF agreed that claimant's injury was compensable, and a binding order made SAIF responsible for claimant's neck condition. SAIF paid a number of medical bills (totaling over $11,400) related to that accepted condition, before claimant submitted the four bills at issue. The late payment of those four medical bills was not a denial of the **<320 Or 229/230>** claim and, therefore, did not entitle claimant to attorney fees under ORS 656.386(1).

The majority turns ORS 656.262(6) on its head. As just noted, that statute provides that an insurer or self-insured employer who has accepted a claim in good faith, but who "later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim," may, within two years, "revoke the claim acceptance and issue a formal notice of claim denial." Also, as just noted, SAIF accepted claimant's claim, and a binding order made SAIF responsible for it. When SAIF disagreed with four of claimant's many medical bills and failed to pay them within 90 days of receipt, SAIF did not "revoke the claim acceptance and issue a formal notice of claim denial." The reason was, of course, that SAIF did not then, and does not now, assert that the claim is not compensable or that it is not responsible for the claim; it simply disagreed with the amount of four of claimant's many medical bills and paid them more than 90 days after receiving them.

The majority holds that, because SAIF failed to follow ORS 656.262(6), it *did* actually "revoke the claim acceptance" and was subject to paying attorney fees for doing so. 320 Or at 209-19. That reasoning is backwards. This was an accepted claim. When SAIF did not follow the procedure set forth in ORS 656.262(6) for "revoking the claim acceptance," *the claim acceptance was not revoked, and the claim*

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[6] ORS 656.262(6) requires that an employer or insurer respond within 90 days to claims for compensation in the first instance. The Board has applied the time limit in ORS 656.262(6) to claims for payment of medical services since 1983, *Billy J. Eubanks*, 35 Van Natta 131 (1983). This court assumed the correctness of that application in *Ellis v. McCall Insulation*, *supra* note 4, 308 Or at 77.

remained an accepted claim. There was no denial of the claim. Perhaps the convoluted reasoning of the majority stems from an effort to avoid the fact that ORS 656.262(6) uses the term "the claim" in the same manner as I assert it is used in ORS 656.386(1) -- to mean the original claim for compensation regarding the overall injury or condition.[7]

320 Or 231> Even using the majority's definition of "claim," under which each of the medical bills was a "claim," there was no denial. There was only late payment, for which a penalty is exclusive of attorney fees. *See* ORS 656.262(10)(a) (penalty is exclusive of attorney fees for late payment of benefits).

A related, and equally fundamental, error of the majority is its use of the usual statutory definitions of "claim" and "compensation." 320 Or at 201-05. This court construed ORS 656.003 in *Astleford v. SAIF*, 319 Or 225, 232-33, 874 P2d 1329 (1994):

> "With respect to ORS 656.003, this court implicitly concluded in *SAIF v. Stephen*, [308 Or 41, 774 P2d 1103 (1989),] that the legislature did not seek uniformity of definitions unless a different definition is *compelled*, but rather sought uniformity only so far as it is *appropriate* to the sensible functioning of the workers' compensation system as a whole. *See* Webster's Third New Int'l Dictionary 1929 (unabridged ed 1993) ('require' means, among other things, 'to call for as suitable or appropriate in a particular case'). *See also Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992) (when Supreme Court construes a statute, that construction becomes part of the statute). Thus, under ORS 656.003, 'the context * * * requires' that a given statutory definition not apply when the context -- including the structure and purpose of the workers' compensation scheme as a whole -- demonstrates that the use of that given definition would be inappropriate, because the result of such use would conflict with one or more aspects of that structure or purpose. We proceed to apply that standard to the question at hand."

Under the *Astleford* standard, "the context * * * requires," ORS 656.003, that the statutory definitions of "claim" and "compensation" not apply here. There are at least two reasons why "the context * * * requires" that those definitions not apply in this case:

1. ORS 656.386(1) refers to a "decision denying *the* claim for compensation." (Emphasis added.) The use of "the" before "claim" implies that there is a single, previously **<320 Or 231/232>** defined "claim" being referred to -- the original claim for the injury or condition, rather than every medical bill thereafter sent in on the accepted claim.

2. This court already had construed the phrase "denying the claim for compensation" in the other sentences in ORS 656.386(1) definitively to mean the original claim for the injury or condition, before the disputed third sentence was added to that section. Because of those decisions concerning the other sentences in ORS 656.386(1), the majority's reading puts claimants who prevail before a hearing begins in a different and more favorable position than claimants who prevail after a hearing takes place. The legislature sought parity, not disparity.

To summarize, there was no "decision denying the claim for compensation" in this case. Claimant is not entitled to an attorney fee under ORS 656.386(1), and I dissent from the majority's contrary holding.

Carson, C.J., and Gillette, J., join in this opinion.

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[7] The text of ORS 656.262(6) makes clear that the legislature used the term "claim" in that provision to mean the original claim for compensation regarding the overall injury or condition. The text of that provision also distinguishes between "a claim" and "medical benefits." For example, ORS 656.262(6) provides in part:

> "However, if the worker requests a hearing on such [formal backup] 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*. * * * Pending acceptance or denial of *a claim*, compensation payable to a claimant does not include the costs of *medical benefits* or burial expenses. * * * The notice of acceptance shall:
>
> "(a) Specify *what conditions* are compensable.
>
> "(b) Advise the claimant whether *the claim* is considered disabling or nondisabling." (Emphasis added.)

Cite as 129 Or App 255 (1994) July 27, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert G. Fuls, Claimant.

ROBERT G. **FULS**, Petitioner,
v.
SAIF CORPORATION, DONALD R. GARNER, TRAVELERS INSURANCE COMPANY and SUNSET GLASS COMPANY, Respondents.
(WCB 91-01005, 90-17213; CA A76999)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 24, 1993.

Edward J. Harri argued the cause for petitioner. With him on the brief were Stanley Fields and Law Offices of Michael B. Dye.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents SAIF corporation and Donald R. Garner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Jerald P. Keene and Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., filed the brief for respondents Travelers Insurance Company and Sunset Glass Company.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

DEITS, P.J.

Affirmed.

*Haselton, J., *vice* Durham, J.

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129 Or App 257> Claimant seeks review of an order of the Workers' Compensation Board denying the compensability of his conversion reaction. The Board denied compensability on the ground that the conditions that caused his conversion reaction were "generally inherent in every working situation." ORS 656.802(3)(b). We review for errors of law and substantial evidence, ORS 656.298(6), and affirm.

We take the facts as found by the referee and adopted by the Board. In 1976, claimant sustained an on-the-job injury. Multidiagnostic tests were carried out between 1976 and 1985 which revealed no pathological orthopedic or neurological problem. A number of examiners who saw claimant believed that his condition may have had a strong psychological component. However, before February, 1990, no treatment for that condition was recommended.

In July, 1989, claimant began work as a gas attendant for Chuck's Texaco, insured by SAIF. As the Board found:

> "On February 23, 1990, while at work[,] * * * he sustained a minor shaking incident when he was grabbed from behind in a 'bear hug.' This led to a complete collapse, including loss of sensation, strength in the legs, and paralysis from the neck down. Claimant was immediately seen at the emergency room where Dr. Lewis found no physical problem at all. He was diagnosed as having an hysterical reaction and discharged without treatment.
>
> "Despite severe symptoms, claimant remained medically stationary. He returned to work on regular duty two days later. He continues to be symptomatic in the same areas as prior to the February 1990 incident. There is no change in symptoms and no new objective findings.
>
> "He did not return to [his treating physician] until August of 1990, approximately six months after the shaking incident. Additional diagnostic tests were again negative. [His treating physician] found no new injury, no pathological worsening of the preexisting condition, and at best a recurrence of symptoms dating from the prior injuries of 1976 and 1980."

The referee concluded that claimant had not established either a new physical injury or an aggravation of a **<129 Or App 257/258>** preexisting physical condition. However, the referee concluded that claimant's claim for his conversion reaction was compensable as an accidental injury, under ORS 656.005(7), because it was caused, in material part, by the February, 1990, "bear hug." The

referee rejected SAIF's argument that ORS 656.802, specifically subsection (3) of that statute relating to occupational diseases in the form of mental disorders, applied to claimant's claim for his conversion reaction. Accordingly, the referee reversed SAIF's *de facto* denial of claimant's claim for a conversion reaction.

SAIF appealed to the Board.[1] The Board adopted the referee's findings of fact, but reversed her conclusion that claimant's conversion reaction was compensable. The Board reasoned:

> "The Referee concluded that claimant established the compensability of his psychological condition, based on the finding that the February 1990 work incident was a material contributing cause of the condition. In applying the 'material contributing cause' standard, the Referee rejected SAIF's argument that the psychological condition must be analyzed as an occupational disease under ORS 656.802. The Referee reasoned, instead, that the appropriate standard is the same as that required to prove the compensability of a psychological condition following an industrial injury. On review, SAIF reasserts its argument that claimant's claim must be analyzed as an occupational disease under ORS 656.802. We agree.
>
> "We note that claimant's psychological condition is not alleged to be a consequence of an industrial injury. Rather, it is alleged to have resulted from a February 1990 work incident in which a customer greeted him by grabbing his arms from behind and shaking him. Thus, we conclude that claimant is seeking to establish that his psychological condition is an independently compensable result of on-the-job stress.
>
> "Subsequent to the Referee's order, the Court of Appeals held in *SAIF v. Hukari*, 113 Or App 475 [833 P2d 1307, *rev den* 314 Or 391 (1992)], that 'any claim that a condition is *independently compensable* because it was *caused by on-the-job stress*, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of **<129 Or App 258/259>** whether the condition is mental or physical, must be treated as an occupational claim under ORS 656.802.' [Emphasis in original.] Therefore, in order to prevail in this case, claimant must satisfy the requirements of establishing a compensable mental disorder under ORS 656.802(2) and (3)." (Citation omitted.)

Claimant argues that the Board erred in holding that ORS 656.802 applied to his claim for a conversion reaction. He asserts that his conversion reaction was *not* the result of on-the-job stress; rather, he contends that the condition was the result of the "bear-hug." Claimant argues that, because of that, the referee correctly analyzed his claim for a conversion reaction as an accidental injury under ORS 656.005(7). As we will discuss, we conclude that because claimant is seeking to establish the independent compensability of a mental disorder, it must be analyzed as an occupational disease under ORS 656.802. Therefore, it is unnecessary to address the question of whether the alleged cause here was stress or the physical act of the "bear hug."

As noted above, the Board concluded, relying on *SAIF v. Hukari, supra*, that it must be analyzed under ORS 656.802 because it involved a condition that was allegedly caused by on-the-job stress. That conclusion, however, is incorrect based on a recent decision of the Supreme Court that rejected the holding that any claim based on stress must be analyzed as an occupational disease claim. *Mathel v. Josephine County*, 319 Or 235, ___ P2d ___ (1994). In *Mathel, supra*, the court concluded that the alleged *cause* of a condition should not determine whether the claim is for an injury or a disease. Rather, it is whether the condition is an "event" or an "ongoing condition[] or state[] of the body or mind" that determines whether the claim is for an injury or a disease. *Mathel v. Josephine County, supra*, (319 Or at 242). Accordingly, a condition that is allegedly caused by stress, the onset of which was sudden and unexpected, could be an injury claim.

Although the Board's reason for concluding that ORS 656.802 applied to claimant's claim for a conversion reaction was faulty because of the recent decision in *Mathel*, we believe that the Board's conclusion was right for another reason. ORS 656.802(1) defines occupational disease as

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[1] Claimant did not seek Board review of the referee's order.

129 Or App 260> "any disease or infection arising out of and in the course of employment * * * which requires medical services or results in disability or death, including:

"* * * * *

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death."

ORS 656.802(3) provides that:

"*Notwithstanding any other provision of this chapter*, a mental disorder is not compensable *under this chapter*:

"(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

"(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

"(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment." (Emphasis supplied.)

Claimant agrees that his conversion reaction is properly diagnosed as a mental disorder and that his claim is an initial claim for the independent compensability of his mental disorder. ORS 656.802(1)(b) provides that an "occupational disease," for purposes of that chapter, includes any mental disorder which results in disability or death. In addition, ORS 656.802(3), by its express terms, applies to all claims for mental disorders under ORS chapter 656, "notwithstanding any other provisions of [the] chapter." We conclude that ORS 656.802 applies to any claim for the independent compensability of a mental disorder under ORS chapter 656.

The Supreme Court's analysis in its recent decision in *Dibrito v. SAIF*, 319 Or 244, ___ P2d ___ (1994), indicates that the court, at least impliedly, construed ORS 656.802 as applying to all initial claims for the independent compensability of a mental disorder. In *Dibrito*, the claimant, who had preexisting colitis and a preexisting personality disorder, filed a worker's compensation claim for an episode **<129 Or App 260/261>** of colitis and psychological symptoms that she alleged had resulted from a meeting with her supervisor. The Board had concluded that claimant's claim was for physical and mental conditions caused by on-the-job stress and, relying on *SAIF v. Hukari, supra*, determined that her claim was not compensable, because she had not met the requirements of ORS 656.802. In reversing the Board's order, the court held that,

> "in reviewing the record of a worker's compensation claim, the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable. In this case, if claimant's claim was based on her episode of colitis, whether caused by physical factors, by job stress, or by both, ORS 656.005(7) applies, because that episode is an 'event' constituting an accidental injury. If, on the other hand, her claim was based on her personality disorder, ORS 656.802 (relating to occupational diseases in the form of mental disorders) applies, and the requirements of that provision must be met, whether the cause of the mental disorder was physical, non-physical, or both. * * * Finally, if claimant's claim encompasses both her episode of colitis and her personality disorder, the Board must analyze each claim separately under the applicable provision." 319 Or at 248.

In *Dibrito*, the court held that ORS 656.802 applied to claimant's claim for psychological symptoms and that ORS 656.005(7) applied to her claim for an episode of colitis, despite the fact that both conditions were sudden in onset and allegedly resulted from the same work incident. Because we hold that ORS 656.802 applies to any initial claim for the independent compensability of a condition that constitutes a mental disorder, we conclude that the Board was correct in analyzing the claim under that statute.

Claimant next argues that the Board erred in its conclusion that his conversion reaction was not compensable under ORS 656.802(3) because the conditions which caused it were conditions inherent in every working situation. The Board reasoned:

> "We are not persuaded that the employment conditions producing claimant's conversion hysteria are conditions other than those generally inherent in every working situation. Virtually every working interaction involves some degree of interaction with co-employees and/or the public, whether it be verbal exchanges or physical contact. While we **<129 Or App 261/262>** acknowledge that not all types of interaction are generally inherent in every working situation, we recognize that those types that are inherent in every working situation vary with the individuals involved. The 'bear hug' which claimant received * * * is certainly a more physical type of interaction; however, we are not prepared to find that it is outside the range of behavior that occurs in every working situation.
>
> "For that reason, we do not find that claimant sustained his burden of proving all of the elements of an occupational disease claim for a mental disorder under ORS 656.802(3). SAIF's denial of claimant's conversion reaction is upheld."

Here, the Board determined that the "bear-hug" that claimant received from a customer was not outside the range of behavior or physical interaction that occurs in every working situation. We agree with the Board's determination.

Affirmed.

Cite as 129 Or App 263 (1994) July 27, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JEFFREY **BENZINGER**, SHARON BYERS, SANDRA COLLINS, RICHARD FRIEND, TEDDY MOULTON, BLAIN YOUNG, SHARON L. ALLEN, ANNIE BARROW, LINDA CARPENTER, SUSAN CHRISTENSEN, RUSSELL H. FOWLER, RICHARD E. HAYES, PATRICK McCALLUM, DEBRA RAY-SPUHLER, DELBERT SMELSER, PHILIP STERLE, JR., STEPHEN R. SUNDSTROM, BERNARD E. TORRANCE, WALTER VANHOOSER and VIOLA WALTERS, Plaintiffs,
and JAMES G. HARRIS, Respondent,
v.
OREGON **DEPARTMENT OF INSURANCE AND FINANCE**, acting through the WORKERS' COMPENSATION DIVISION, APPELLATE UNIT, agencies of the STATE OF OREGON, Appellants,
and LARRY YOUNG, Defendant.
(A9102-01201; CA A77673)

Appeal from Circuit Court, Multnomah County.
Harl H. Haas, Judge.
Argued and submitted March 14, 1994.
John T. Bagg, Assistant Attorney General, argued the cause for appellants. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Kevin N. Keaney argued the cause for respondent. With him on the brief was Pozzi Wilson & Atchison.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Reversed.

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129 Or App 266> Defendant Oregon Department of Insurance and Finance (DIF)[1] appeals a circuit court order requiring that it issue a reconsideration order taking into account the findings of a panel of medical arbiters. We reverse.

Plaintiff Benzinger and others initiated this action under ORS 183.490,[2] seeking to compel DIF to reconsider determination orders issued under ORS 656.286(6)(a) (*since amended* by Or Laws 1991, ch 502, 1). The complaint was later amended to include plaintiff Harris. Originally, DIF had delayed issuing the reconsideration orders, because plaintiffs had not been examined by a medical arbiter or panel of medical arbiters, as required by ORS 686.268(7). This delay was in the face of the 15-day time limit imposed by the version of ORS 656.268(6)(a) then in effect. The circuit court decided that the time limit was mandatory and, on appeal, we affirmed in *Benzinger v. Oregon Dept. of Ins. and Finance*, 107 Or App 449, 812 P2d 36 (1991). Thereafter, the circuit court, on August 22, 1991, entered a judgment requiring DIF to take certain actions. As relevant to this proceeding, the judgment provided:

> "Defendant is enjoined to issue reconsideration orders within 10 days of entry of this judgment, regardless of whether the reconsideration process has been completed * * *."

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[1] DIF has been renamed the Department of Consumer and Business Services. Larry Young, DIF's Administrator, is not a party to this appeal.

[2] ORS 183.490 provides:

> "The court may, upon petition as described in ORS 183.484 [review of orders in other than contested cases], compel an agency to act where it has unlawfully refused to act or make a decision or unreasonably delayed taking action or making a decision."

DIF issued a reconsideration order for plaintiff Harris on August 30, 1991, affirming the determination order. However, DIF advised Harris that, because the medical arbiters were unable to complete their examination and submit a report within the required time limits, the appellate unit was unable to complete a substantive review.

Plaintiff Harris filed a request for a hearing to review the reconsideration order. ORS 656.283. In the interim, **<129 Or App 266/267>** Harris attended an examination with a panel of medical arbiters. On June 5, 1992, a referee entered an order dismissing Harris's request for hearing and setting aside DIF's August 30, 1991, reconsideration order. In addition, the referee remanded the case to DIF, stating:

> "[J]urisdiction remains with the Appellate Unit [of DIF] and claimant shall demand completion of the reconsideration process and entry of an Order on Reconsideration."

After receiving the referee's order, Harris requested that DIF issue a new reconsideration order that considered the medical arbiter's report, and DIF refused.

Harris then moved in the circuit court for an order to show cause why DIF should not be held in contempt for not issuing a valid reconsideration order. A hearing was held and, on November 20, 1992, the court issued the order from which DIF now appeals. That order required DIF to

> "issue a reconsideration order which considers the findings of the panel of medical arbiters who reported on the impairment of [Harris]. Defendants shall issue the reconsideration order within 15 days of this order."

DIF assigns error to the court's order. We review for errors of law. *See Wyers v. Dressler*, 42 Or App 799, 601 P2d 1268 (1979) *rev den* 288 Or 527 (1980).

The court order on review requires DIF to act on a case that is before DIF only because of the referee's remand to DIF. However, in *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 860 P2d 822 (1993), we expressly rejected a construction of the worker's compensation statue that would allow a referee to remand cases to DIF. We noted that "the legislature and the courts have emphasized that speedy processing and resolution of claims is a primary goal" of that statute. 123 Or App at 317.[3] The court below recognized the importance of this goal in its first order, when it ordered DIF to issue reconsideration orders "regardless of whether the reconsideration process has been completed." The referee had no authority to remand the case to DIF. Therefore, it was not properly before DIF, and the circuit court erred in ordering DIF to issue a new order.

129 Or App 268> Harris contends that, unless we uphold the circuit court, he will never receive a hearing and that result violates the Fifth Amendment to the United States Constitution and Article I, section 10, of the Oregon Constitution. Although we sympathize with Harris' plight, he created the predicament in which he now finds himself. In *Benzinger v. Oregon Dept. of Ins. and Finance, supra*, we agreed with the argument that the time deadlines for preparing reconsideration orders were mandatory. Accordingly, the circuit court instructed DIF to prepare reconsideration orders "regardless of whether the reconsideration process has been completed." Harris cannot now ask for a second "bite of the apple" to remedy the very situation that resulted from his choice of strategy.

Reversed.

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[3] *Pacheco-Gonzalez, supra*, was decided after the order in this case issued.

Cite as 129 Or App 283 (1994) July 27, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William R. Denny, Claimant.

WILLIAM R. **DENNY**, Petitioner,
v.
MCKENNEY CRANE and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(91-03414; CA A75326)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 3, 1993.
Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun & Green.
James D. McVittie argued the cause and filed the brief for respondents.
Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.
HASELTON, J.
Affirmed.
*Haselton, J., *vice* Durham, J.

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129 Or App 285> Claimant seeks review of an order of the Workers' Compensation Board denying compensability of his current condition and denying his aggravation claim. We affirm. The facts, as found by the Board, are undisputed. Claimant sustained a compensable head injury on March 19, 1990, when he accidentally walked into a steel crane while at work at McKenney Crane (employer). Claimant returned to work 11 days after he was injured, but experienced severe daily headaches for several weeks. Although the headaches became less severe, claimant continued to have headaches and persistent pain in his neck and shoulders. In May 1990, employer closed claimant's claim, awarding temporary disability benefits but no permanent partial disability benefits. In August 1990, employer laid claimant off.

In September 1990, claimant went to work for Specialty Truck Parts. His headaches and neck and shoulder pain not only persisted, but gradually worsened and, by December, 1990, had become intermittently severe. In addition, claimant had begun experiencing lower extremity pain. On December 31, 1990, after he was restricted to light work at Specialty Truck Parts following an on-the-job lifting incident, claimant gave employer notice of that incident and the resulting restrictions. Employer construed that notice as signalling claimant's intent to reopen his claim.

In February 1991, an independent medical examination determined that, since at least 1988, before claimant's March 1990 injury, claimant had suffered from Scheuermann's Disease,[1] which causes abnormal spinal curvature. The resultant postural abnormalities led, in turn, to low back and neck pain. Because of that diagnosis, in March 1991, employer's carrier denied compensability of claimant's current condition and further denied claimant's aggravation claim.

129 Or App 286> The referee set aside employer's denial of compensability and upheld the aggravation denial. The Board reversed the referee on compensability of claimant's current condition and affirmed on the denial of aggravation. In particular, it held that claimant's Scheuermann's Disease was a preexisting disease and that claimant had failed to prove under ORS 656.005(7)(a)(B) that his March 19, 1990 compensable injury was the major contributing cause of his current need for treatment.

Claimant challenges the Board's determination on the compensability of his current condition on three grounds. First, relying on *Georgia-Pacific v. Piwowar*, 305 Or 494, 501, 753 P2d 948 (1988), he contends that, because his current claim was based on the same condition employer previously accepted, employer cannot deny treatment for the current condition. Second, he argues that the Board erred in

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[1] Scheuermann's Disease, or osteochondrosis, is a juvenile onset disease, which begins as degeneration followed by regeneration. *Dorland's Illustrated Medical Dictionary*, 462, 1105 (25th ed 1974).

It is undisputed that claimant's Scheuermann's Disease was asymptomatic until the March 19, 1990 accident.

applying the major contributing cause standard, rather than the material contributing cause test in determining compensability of his current condition. Third, he argues that the Board erred in finding his Scheuermann's disease a preexisting condition and not a predisposition.

Claimant's reading of *Georgia-Pacific v. Piwowar, supra,* is overbroad. In *Piwowar,* the Supreme Court held that by accepting a "sore back" claim, the employer had accepted the compensability of the condition that had caused the sore back, although that condition was not discovered until after the claim had been accepted. The court concluded that, because Georgia-Pacific had accepted a claim for a symptom of an underlying disease, and not a separate condition, Georgia-Pacific had accepted the compensability of the underlying condition. 305 Or at 501-02. In this case, unlike in *Piwowar,* employer did not accept a claim for headaches, a symptom of claimant's Scheuermann's Disease. Rather, employer's acceptance was limited to the injury indicated on claimant's compensation claim Form 801, a "laceration."[2] "The scope of acceptance corresponds to the condition specified in the acceptance notice * * *." *Georgia-Pacific v.* **<129 Or App 286/287>** *Piwowar, supra,* 305 Or at 501. Because claimant's headaches were not accepted, his *Piwowar*-based argument fails.

Claimant next contends that the Board erred in applying the major contributing cause test in determining the compensability of his current condition. He argues, relying on *Albany General Hospital v. Gasperino,* 113 Or App 411, 833 P2d 1292 (1992), that under ORS 656.005(7)(a) the material contributing cause test applies. ORS 656.005(7)(a) provides:

> "A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.
>
> "(B) If a compensable injury combines with a preexisiting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

In *Albany General Hospital v. Gasperino, supra,* we discussed the limitation in subparagraph (A) and found that, because the claimant's condition was directly caused by the industrial accident, and was not a consequence of the compensable injury, subparagraph (A) was inapplicable. Consequently, the major contributing cause standard was inapposite, and the material contributing cause standard controlled.

In this case, the inquiry focuses on subparagraph (B), not (A). The carrier argued, and the Board agreed, that because claimant's Scheuermann's disease was a preexisting condition, the major contributing cause standard in subparagraph (B) applied to determine the compensability of claimant's current condition. The Board further found that claimant's Scheuermann's disease, and not his compensable injury, was the major contributing cause of his current condition. That determination accords with substantial evidence.

129 Or App 288> Claimant attempts to avoid this conclusion by asserting that because his Scheuermann's disease is a mere "predisposition," and not a preexisting condition, subparagraph (B) does not apply. Claimant's putative distinction between a "predisposition" and "preexisting condition" is unclear. In any event, whether claimant's Scheuermann's disease is a preexisting condition is a complex medical question requiring medical testimony. *See Uris v. Compensation Dept.,* 247 Or 420, 424, 427 P2d 753, 430 P2d 861 (1967); *Kassahn v. Publishers Paper Co.,* 76 Or App 105, 109, 708 P2d 626 (1985), *rev den* 300 Or 546 (1986). Here, the Board found that "[s]ince at least 1988, claimant has had abnormal curvature of the thoracic spine" consistent with Scheuermann's disease. Because substantial evidence, including x-rays, supports that finding, we affirm the Board's conclusion that claimant's Scheuermann's disease is a preexisiting condition.

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[2] Here, as in *Georgia-Pacific v. Piwowar, supra,* it is difficult to pinpoint employer's acceptance. However, employer acknowledged throughout these proceedings and at oral argument that it had accepted claimant's claim as specified in his Form 801.

Finally, claimant argues that the Board erred in affirming the denial of his aggravation claim. We disagree. The Board's determination that claimant had failed to prove a worsening of his condition is supported by substantial evidence in the record. See ORS 183.482(8); ORS 656.273(1).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Myron R. Shaffer, Claimant.

SAIF CORPORATION/CHUCK CHANEY'S AUTOMOTIVE SERVICE, INC., Petitioner,
v.
MYRON R. **SHAFFER** and ARGONAUT INSURANCE/CHUCK CHANEY'S AUTOMOTIVE SERVICE, INC., Respondents.
(91-08527, 92-15856; CA A78290)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 24, 1993.

Steve Cotton, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Robert Wollheim argued the cause for respondent Myron R. Shaffer. With him on the brief was Welch, Bruun, Green & Wollheim.

Darren L. Otto argued the cause for respondent Argonaut Insurance Company/Chuck Chaney's Automotive Service, Inc. With him on the brief was Scheminske & Lyons.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

HASELTON, J.

Affirmed.

*Haselton, J., *vice* Durham, J.

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129 Or App 291> SAIF Corporation seeks review of an order of the Workers' Compensation Board setting aside SAIF's denial based on lack of coverage for claimant's right knee injury. We affirm.

In January 1982, claimant fell at work, striking his right knee against a concrete floor. At that time, his employer's insurance carrier was Argonaut Insurance Co. Claimant retired from his job in 1983.

In October 1987, claimant filed an injury claim, alleging an on-the-job injury to his right knee; claimant erroneously identified the injury as occurring in 1984, and not 1982. Claimant's former employer referred the claim to SAIF, which had begun insuring the employer in 1985, which was after the date of either the actual or the erroneously designated date of the incident. On January 20, 1988, SAIF issued a notice of claim acceptance for post-traumatic arthritis of the right knee. Claimant subsequently underwent surgery and was ultimately awarded 85 percent scheduled permanent partial disability. On June 18, 1991, three-and-one-half years after accepting the claim, SAIF issued a denial letter, asserting that it did not cover claimant's employer on the date of the injury. Thereafter, SAIF issued a disclaimer of responsibility, asserting that Argonaut was the responsible insurer. Claimant then filed a claim with Argonaut, which denied compensability, asserting that it was materially prejudiced by the filing of the claim more than seven (or nine) years after the injury. Argonaut also denied responsibility, asserting that SAIF's denial was unlawful.

The referee set aside SAIF's denial and the Board, relying on *Garcia v. SAIF*, 108 Or App 653, 816 P2d 1188 (1991), affirmed.

Before addressing *Garcia v. SAIF, supra*, we consider the application of ORS 656.262(6). That statute 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 **<129 Or App 291/292>** knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that *the claim is not compensable or evidence that the paying agent is not responsible for the claim*, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial." (Emphasis supplied.)

If SAIF's denial of coverage is a denial based on "evidence that the paying agent is not responsible for the claim,"[1] that denial might be barred by the statute's two-year limitation.

Whether ORS 656.262(6) encompasses denials for lack of coverage is a matter of statutory construction. In resolving that question, we look first to the statute's text and context and then, if that inquiry is inconclusive, to legislative history. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993).

The statutory text, when viewed in isolation, is ambiguous. Lack of "responsibility" is a broad concept that could encompass virtually any assertion by an employer or carrier[2] that it is not obliged to pay compensation for any reason unrelated to compensability, including lack of coverage.

In statutory context, "responsibility" is a more precise concept. Under the workers' compensation statutes, "responsibility" refers to disputes over:

> "(a) Which of several subject employers is the true employer of a claimant worker;
>
> "(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;
>
> "(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or
>
> **129 Or App 293>** "(d) Joint employment by two or more employers * * *." ORS 656.307(1).

SAIF's denial for lack of coverage fell within the second of these categories of "responsibility": Both SAIF and Argonaut provided coverage to claimant's employer. Indeed, shortly after issuing its denial letter asserting a lack of coverage, SAIF issued its disclaimer of responsibility, identifying Argonaut as the employer's carrier on the date of injury.

The limited legislative history of the 1990 amendments to ORS 656.262(6) buttresses our belief that that statute addresses back-up denials based on lack of coverage. Before 1990, back-up denials of compensability or responsibility were not allowed except upon a showing of fraud, misrepresentation, or illegal activity by the claimant. *See Ebb Tide Enterprises v. Tucker*, 303 Or 459, 738 P2d 194 (1987); *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983).

Conversely, and subject to certain limitations described below, denials based on lack of coverage were allowed, so long as those denials pertained to intramural disputes between carriers. To the extent, however, that a "coverage" dispute implicated a claimant's entitlement to compensation on an accepted claim, we held that *Bauman v. SAIF, supra*, prohibited such a denial. *See, e.g., Oak Crest Care Center v. Bond*, 101 Or App 15, 18, 789 P2d 6, *rev den* 310 Or 121 (1990) ("*Bauman* protects claimants against

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[1] Such a denial does not pertain to compensability. *See Oak Crest Care Center v. Bond*, 101 Or App 15, 19, 789 P2d 6, *rev den* 310 Or 121 (1990).

[2] No statute expressly defines "paying agent" for purposes of ORS 656.262(6). However, ORS 656.576 defines "paying agency" for purposes of ORS 656.578 to ORS 656.595 as "the self-insured employer or insurer paying benefits to the worker or beneficiaries." That definition, although not expressly controlling, is instructive.

vacillation by an employer or an insurance carrier regarding acceptance of compensability or responsibility"); *D Maintenance Company v. Mischke*, 84 Or App 218, 221-22, 733 P2d 903, *rev den* 303 Or 483 (1987) (under *Bauman*, "the first employer or insurer must continue to pay compensation *unless and until* someone else is determined to be responsible" (emphasis in original)).

Thus, we distinguished between (1) "pure" coverage denials that merely contested *who* would pay compensation on an accepted claim and (2) "back-up" denials for lack of coverage that put at risk *whether* a claimant would continue to receive compensation on an accepted claim. *Bauman* permitted the former, but barred the latter. *Compare Oak Crest Care Center v. Bond, supra*, 101 Or App at 19 (permitting "pure" coverage denial) *with Garcia v. SAIF, supra*, 108 Or **<129 Or App 293/294>** App at 658 (prohibiting "back-up" denial for lack of coverage, where denial put claimant's entitlement to continued compensation "at risk").

In amending ORS 656.262(6) in 1990, the legislature "specifically sought to change the law articulated in *Bauman v. SAIF.*" *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 285, 850 P2d 396 (1993); *accord* Tape Recording, Senate Floor Debate, Special Legislative Session, May 7, 1990, Tape 4A at 155 ("What this section of the bill does is that it reverses the *Bauman* decision" (remarks of Senator Brenneman)). The 1990 amendments were, thus, designed to permit, subject to the two-year limitation, the sort of back-up denials prohibited by *Bauman* and its progeny. Although nothing in the 1990 legislative history expressly refers to back-up denials based on lack of coverage, there is no reason to believe the legislature intended to treat such denials differently from any other denials previously barred under *Bauman*. Thus, we conclude that ORS 656.262(6) permits carriers to issue such denials, subject to the statute's two-year limitation from the date of claim acceptance.

Here, SAIF's coverage denial is a back-up denial that would have been barred under *Bauman*. SAIF accepted the claim when it reasonably could have determined that it did not provide coverage on the date of the injury. Moreover, there is substantial evidence that the sheer passage of time would severely prejudice claimant's ability to litigate compensability against Argonaut. For example, claimant's recollection of the pertinent events has faded, and his right knee was surgically replaced years ago. Thus, SAIF's denial, coupled with Argonaut's denial of compensability, placed claimant's right to compensation "at risk." *See Garcia v. SAIF, supra.*[3]

Because SAIF's back-up denial otherwise falls within ORS 656.262(6), we must consider whether the statutory two-year limitation applies where, as here, the claim was **<129 Or App 294/295>** accepted before the statute's effective date, July 1, 1990, but the back-up denial was issued after that date. Although "[t]he general rule * * * is that a statute that *shortens* a limitations period applies prospectively if the legislature does not express a contrary intent," a statute that *extends* a civil limitations period is, ordinarily, given retroactive application. *Boone v. Wright*, 314 Or 135, 139, 836 P2d 727 (1992). (Emphasis supplied.) *See also Nichols v. Wilbur*, 256 Or 418, 419-20, 473 P2d 1022 (1970).

The 1990 amendment to ORS 656.767(6) "extended" the limitations period for *Bauman* back-up denials by prescribing a two-year limitation for asserting denials that had previously been barred altogether. Consequently, the statutory two-year limitation governs back-up denials of coverage of claims accepted before July 1, 1990. Because SAIF issued its back-up denial here more than two years after the date of claim acceptance, that denial was time-barred.

Affirmed.

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[3] SAIF attempts to distinguish this case from *Garcia* by arguing that *Garcia* limits lack of coverage denials "only in one instance: where the insurer has advised claimant that he did not need to pursue his claim against other potentially responsible entities." This is far too restrictive a reading of *Garcia* and our other decisions addressing lack of coverage denials. Those precedents prohibit back-up denials based on lack of coverage in *all* instances in which such denials put at risk claimant's right to compensation on an accepted claim.

Cite as 129 Or App 314 (1994) August 3, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald Martin, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
DONALD **MARTIN**, Respondent.
(92-10346; CA A80804)

Judicial Review from Workers' Compensation Board.

On petitioner's motion for reconsideration filed May 6, 1994. Opinion filed May 4, 1994, 127 Or App 739, 872 P2d 446.

Adam T. Stamper and Cowling & Heysell for motion.

Pamela A. Schultz, *contra.*

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

WARREN, P.J.

Reconsideration allowed; opinion modified; Board's order that employer reprocess claim vacated; award of attorney fees reversed and remanded for reconsideration; otherwise affirmed.

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129 Or App 316> Employer seeks reconsideration of our decision in this case. 127 Or App 739, 872 P2d 446 (1994). We allow reconsideration and modify the disposition.

In our opinion, we vacated the Board's order that employer reprocess claimant's claim and affirmed the remainder of the order. Employer points out that the Board's order had awarded attorney fees based on claimant's having prevailed on the claims processing issue. Because we vacated the order to reprocess the claim, employer argues that we also should have vacated the award of attorney fees.

On appeal to the Board, employer raised issues concerning whether the referee correctly denied its motion to dismiss the claim, whether it was required to reprocess the claim, and whether sanctions should have been awarded against claimant's counsel for filing a frivolous hearing request. The Board affirmed the referee's denial of the motions to dismiss and for sanctions, and the order that employer reprocess the claim. It also awarded attorney fees for claimant's counsel's efforts "concerning the motion to dismiss and claim processing issues."

Employer is correct that the claim processing issue has now been resolved in its favor, and that issue cannot be a basis for an award of attorney fees. However, because the Board's attorney fee award was based in part on its ruling on the motion to dismiss, which was not challenged on judicial review, we remand for the Board to reconsider the award of attorney fees.

Reconsideration allowed; opinion modified; Board's order that employer reprocess the claim vacated; award of attorney fees reversed and remanded for reconsideration; otherwise affirmed.

Cite as 129 Or App 352 (1994) August 3, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John R. Heath, Claimant.

ANODIZING, INC. and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners - Cross-Respondents,
v.
JOHN R. **HEATH**, Respondent - Cross-Petitioner.
(91-14829, 91-02296; CA A79602)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 18, 1994.
James D. McVittie argued the cause and filed the brief for petitioners - cross-respondents.
Marianne Bottini argued the cause and filed the brief for respondent - cross-petitioner.
Before Richardson, Chief Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed on petition and on cross-petition.

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129 Or App 354> Employer petitions for review of an order of the Workers' Compensation Board that awarded claimant temporary disability benefits. Claimant cross-petitions the determination that his claim was properly closed. We affirm the cross-petition without discussion and write only to address the petition.

Claimant's claim for lumbar strain was closed by determination order on January 3, 1991. Claimant requested reconsideration of the determination order, arguing that the claim was prematurely closed. The Department of Insurance and Finance (DIF)[1] issued its order on reconsideration on May 17, 1991, in which it held that the claim was prematurely closed and rescinded the January determination order. Employer sought a hearing on the order on reconsideration. It did not pay claimant temporary disability benefits during the pendency of the appeal. The referee, and then the Board, held that the claim had not been closed prematurely, set aside the May order on reconsideration and reinstated the January determination order. The Board awarded claimant temporary disability benefits from May 17, 1991, through December 2, 1991, the date of the referee's order. In awarding temporary benefits pending the decision on its request for hearing, the Board relied on ORS 656.313, which provides, in part:

> "(1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order * * * stays payment of the compensation appealed, *except for*:
>
> "(A) Temporary disability benefits that the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs * * *." (Emphasis supplied.)

The issue on review is whether the Board correctly applied ORS 656.313(1)(a)(A) in awarding claimant temporary disability benefits from the date of the order on reconsideration through the date that order was set aside. Employer argues that, although ORS 656.313(1)(a)(A) provides that it should have paid benefits during the pendency of its request for hearing, the statute does not authorize the **<129 Or App 354/355>** Board to order employer to make those payments in this case, because the Board ultimately determined that claimant was medically stationary when the original determination order issued, with the result that claimant was not entitled to any benefits that would have been paid during that time. Employer relies on *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992). Claimant argues that ORS 656.313(1)(a)(A) plainly requires employer to continue to make payments during the pendency of its appeal, and the Board is authorized to order employer to make those payments, even when it rules in employer's favor on the merits of the appeal. In support of his argument, claimant relies on *Roseburg Forest Products v. McDonald*, 116 Or App 448, 841 P2d 697 (1992).

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[1] The Department of Insurance and Finance has been renamed the Department of Consumer and Business Services.

In *Lebanon Plywood v. Seiber, supra,* the employer accepted the claimant's aggravation claim. The claimant later became medically stationary and, after approximately six months of what were characterized as "processing delays," the claimant's claim was closed by a determination order with an award of permanent partial disability. The employer had not paid any temporary disability benefits through the date of the determination order. The claimant sought a hearing and, ultimately, obtained a decision from the Board awarding him temporary disability benefits through the date of the determination order. We held that the Board did not have the authority to order temporary benefits beyond the date the claimant became medically stationary:

> "When an employer is notified that the injured worker is medically stationary, it will, in most instances, submit the claimant's file to the Department of Insurance and Finance for a determination order, which will designate the medically stationary date and make the appropriate permanent disability award. ORS 656.268(4). Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date. Because of delays in processing, the actual payment of temporary benefits continues until the determination order is issued. That delay results in an overpayment of temporary benefits that the employer is entitled to recoup by deduction from any permanent disability compensation awarded. ORS 656.268(10).
>
> "Here, claimant was not released to return to work, and his claim was closed by a determination order. He had not **<129 Or App 355/356>** received any temporary disability benefits and the processing delay did not result in a procedural overpayment. Payment of temporary disability benefits beyond the medically stationary date is a consequence of the administrative process of claim closure and is not an entitlement. If processing delay does not result in an overpayment, the Board has no authority to impose one." 113 Or App at 654. (Footnote omitted.)

In *Roseburg Forest Products v. McDonald, supra,* the claimant's claim was closed by a determination order that included an award of temporary disability benefits. The employer appealed the order, arguing that the claimant was not entitled to temporary disability benefits, because he had withdrawn from the work force. During the pendency of the appeal, the employer paid no temporary disability benefits. The referee agreed with the employer that the claimant was not "substantively" entitled to the time-loss benefits, because he had left the work force, and the Board ultimately upheld the referee. Meanwhile, the claimant requested a hearing on the employer's failure to pay the temporary disability benefits during the appeal of the determination order. The Board awarded penalties and fees for failure to pay benefits ordered by the determination order, on the basis of an earlier version of ORS 656.313(1), which provided that an employer's appeal does not stay the payment of compensation to a claimant. We affirmed the Board's award of penalties and fees, holding that the statute required employer to pay the temporary disability benefits during the pendency of the appeal, regardless of the outcome of that appeal.

The distinction between the two cases is this: In *Lebanon Plywood,* there was no employer appeal, and the claimant was statutorily entitled to payment of temporary disability benefits only through the medically stationary date. Although the statute did not allow the employer to terminate the payments until the issuance of a determination order, any compensation that the claimant received after the medically stationary date constituted an overpayment, and the employer was entitled to recoup those payments from the claimant out of future awards of compensation. We held that the Board did not have the authority to, in essence, order the employer to make an overpayment of benefits. In *McDonald,* the employer did appeal, and the claimant was statutorily entitled to payment of temporary benefits through the appeal **<129 Or App 356/357>** period. We held that the appeal statute is unconditional, and that the employer must continue paying benefits during an appeal until ordered otherwise. Payment of compensation under the appeal statute did not result in an overpayment. The statute entitled the claimant to benefits throughout the entire appeal period, regardless of the outcome of the appeal. Thus, the Board was not ordering the employer to make an overpayment of benefits, as was the case in *Lebanon Plywood.*

This case is like *McDonald* and unlike *Lebanon Plywood.* Employer appealed the order on reconsideration, which required the payment of temporary disability benefits. ORS 656.313(1)(a)(A) requires employer to continue to pay those benefits during the pendency of the appeal. As in *McDonald,* claimant in this case is entitled to those benefits during the appeal process, regardless of the outcome of the appeal. No overpayment of benefits results, as in *Lebanon Plywood.* Had employer paid the benefits

during the appeal, it would not be entitled to recoup any of those benefits upon obtaining a reversal of the order on reconsideration. The Board, therefore, did not err in awarding temporary disability benefits from the date of the order on reconsideration through the date the order eventually was set aside.

Affirmed on petition and on cross-petition.

Cite as 129 Or App 442 (1994) August 10, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Raymond L. Owen, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
RAYMOND L. **OWEN**, Respondent.
(92-11258; CA A80845)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 24, 1994.
Adam T. Stamper argued the cause for petitioner. With him on the brief was Cowling & Heysell.
Darrell E. Bewley argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and Warren and Riggs, Judges.
DEITS, P.J.
Affirmed.

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129 Or App 444> Employer seeks review of an order of the Workers' Compensation Board affirming an order on reconsideration that awarded claimant 8 percent unscheduled permanent disability. Employer also challenges the Board's award of attorney fees to claimant. We affirm.

Claimant had compensable claims for right knee tendinitis and a low back strain. He was declared medically stationary and the claim was closed by a notice of closure with no award of permanent disability. Claimant requested reconsideration of the impairment decision, asserting that the impairment findings of the attending physician, Dr. Peterson, were wrong. A medical arbiter, Dr. Burr, was appointed. Burr submitted a report to the Department of Insurance and Finance (DIF), finding some disability. Based on those findings, DIF awarded claimant 8 percent unscheduled disability for lost motion in the low back. Employer appealed the reconsideration order. The referee affirmed the permanent partial disability (PPD) award and awarded claimant attorney fees under ORS 656.382(2). Employer then sought Board review, challenging the disability award and seeking a reduction in the award of attorney fees.

At the hearing before the referee, employer sought to introduce as evidence reports from two doctors who also had made findings related to claimant's impairment. Neither of those doctors were claimant's attending physician, nor did the attending physician concur in their findings. The referee and Board refused to admit the two reports into evidence, explaining that the introduction of medical evidence related to impairment was limited to the opinions of the medical arbiter and the attending physician at the time of claim closure. Employer assigns error to the Board's refusal to admit the reports.

As the Board explained in its order, ORS 656.245(3)(b)(B)[1] and ORS 656.268(7)[2] impose limits on the medical **<129 Or App 444/445>** evidence related to impairment that may be admitted before the referee:

> "The employer contends that when there is a medical arbiter's opinion *any* prior impairment findings should be considered in weighing the preponderance of the evidence. We disagree.

> "In each of the cases cited by the employer, we evaluated only the opinions of the attending physician and the medical arbiter. This is consistent with the statutory mandate that provides: 'Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." ORS 656.245(3)(b)(B); *see also Dennis E. Connor*, 43 Van Natta 2799 (1991). The exception refers to impairment findings made by a medical arbiter appointed pursuant to ORS 656.268(7). *See Easter M. Roach*, 44 Van Natta 1740 (1992). The impairment findings of an independent medical examiner may be used for rating claimant's impairment *only* when the attending physician has ratified those findings. *See Raymond D. Lindley*, 44 Van Natta 1217 (1992)." (Emphasis in original.)

Employer argues that the Board's decision is inconsistent with our decision in *Safeway Stores, Inc. v. Smith*, 122 Or App 160, 857 P2d 187 (1993). Employer contends that in *Smith* we held that there is no limitation on evidence that may be received by a referee when reviewing a reconsideration order. That case is not controlling here, however, **<129 Or App 445/446>** because it concerned the admission of evidence relating to the determination of adaptability. In *Smith*, we did not address either ORS 656.245(3) or ORS 656.268(7), which specifically govern the admission of medical evidence relating to impairment. The Board did not err in excluding the evidence offered by employer.

Employer also argues that the Board erred in its award of attorney fees to claimant, because it failed to make findings and to adequately explain the basis for its award. However, as we said in *Leo Polehn Orchards v. Hernandez*, 122 Or App 241, 857 P2d 213, *rev den* 318 Or 97 (1993), although the Board must consider all of the relevant factors in determining the appropriate amount of attorney fees to be awarded, it is not required to make specific findings as to each one. Here, the Board stated:

> "After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee's determination that a reasonable fee for claimant's attorney's services at hearing concerning the extent of unscheduled disability issue is $1,500. In reaching this conclusion, we have particularly considered the attorney's skill and experience, the complexity of the case, and the value of the interest involved, as well as the risk that claimant's attorney's efforts might go uncompensated. We conclude that the attorney fee awarded by the Referee is reasonable."

We conclude that the Board's explanation of its decision was sufficient and that it did not abuse its discretion in awarding attorney fees.

Affirmed.

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[1] ORS 656.245(3)(b)(B) provides, in part:

> "A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

[2] ORS 656.268(7) provides:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. At the request of either of the parties, a panel of three medical arbiters shall be appointed. The arbiter, or panel of the medical arbiters, shall be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005(12)(b)(A) who were selected by the director in consultation with the Board of Medical Examiners for the State of Oregon and the committee referred to in ORS 656.790. The medical arbiter or panel of medial arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. The costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid by the insurer or self-insured employer. The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

Cite as 129 Or App 471 (1994) August 10, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Meridee A. Kaiel, Claimant.

MERIDEE A. **KAIEL**, Petitioner - Cross-Respondent,
v.
NCE **CULTURAL HOMESTAY INSTITUTE**, Respondent - Cross-Petitioner, and
SAIF CORPORATION, Respondent.
(WCB Nos. 91-03467, 90-12953, 90-20519; CA A77214)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 24, 1993.

Robert Wollheim argued the cause for petitioner - cross-respondent. With him on the briefs was Welch, Bruun, Green & Wollheim.

Margaret H. Leek Leiberan argued the cause for respondent - cross-petitioner. With her on the brief were Wallace & Klor, P.C., and Leiberan & Gazeley.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

DEITS, P.J.

Reversed and remanded on petition; affirmed on cross-petition.

*Haselton, J., *vice* Durham, J.

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129 Or App 473> Claimant seeks review of a final order of the Workers' Compensation Board concluding that her injury was noncompensable. On cross-petition, noncomplying employer seeks review of the Board's conclusion that claimant was a subject worker. We reverse on the petition and affirm on the cross-petition.

The facts of the case, as found by the referee and adopted by the Board, are not in dispute. Noncomplying employer (NCE), Cultural Homestay Institute, is an educational exchange organization that contracts with Japanese schools to bring students to the United States for one- to eight-week educational programs. After NCE contracts with a Japanese school to provide a program in a specific city, NCE's area administrator enters into a contract with a "teacher-coordinator" (TC) who agrees to be responsible for conducting that specific program.

In April, 1989, NCE contracted with claimant and Sabin to conduct jointly a three-week program in August in Portland for 15 junior high school students. During the regular school year, claimant works as a second grade teacher's assistant. She has never taught English before. Claimant signed the same contract signed by all of NCE's approximately 1,000 TCs. The contract requires that the TCs recruit host families for the students and their escort, locate a study center for teaching English and prepare an itinerary for the entire program. Claimant was paid $325 per week for three weeks for teaching English and supervising her student group, plus $50 for each host family that she recruited.

NCE requires that the itinerary prepared by the TCs include a number of specific activities, including English instruction three hours per day, four days per week, full-day excursions, half-day outings, cultural exchanges and sports afternoons. The itinerary is prepared based on a budget of $28 per student allocated by NCE. Each activity must conform to NCE's general specifications, as discussed below. NCE also requires that the TCs prepare an itinerary of all optional activities arranged in addition to those required under the contract. The optional activities are not part of the budget. Although NCE does not approve or disapprove any particular **<129 Or App 473/474>** item on an itinerary, it does certify that all of the events specifically required by the contract are included.

Claimant and Sabin strictly followed the itinerary that they had prepared for their group. On August 18, 1989, claimant and Sabin took the students roller-skating at Oaks Park for a scheduled "sports afternoon." The students and the TCs skated, at NCE's expense, from 1:00 to 2:30 p.m. From 2:30 to 3:30 p.m., the scheduled departure time, the students were free to do whatever they wanted, at their own expense, pursuant to the optional activities list. The list included Oaks Park's carnival rides and arcade games. Claimant, who was required to be with the students at all times while at Oaks Park, rode the bumper cars at her own expense with eight or nine of her students. The third time that she

went on the ride, she fractured her right ring finger. Because of complications, her medical bills for the injury total $26,844.

After a contested case hearing, the referee concluded that claimant was an employee of NCE and that she was acting within the course and scope of her employment when she was injured. On review, the Board agreed that claimant was a subject worker, but concluded that her injury did not arise out of and in the course of her employment and, thus, was not compensable.[1] On reconsideration, the Board adhered to its order.

We first address NCE's argument on the cross-petition that the Board erred in concluding that claimant was a subject worker rather than an independent contractor. Under *former* ORS 656.005(27) (renumbered ORS 656.005(28) in 1990), a worker is one who is "subject to the direction and control of an employer." An employer is one who has "the right to direct and control the services of any person." ORS 656.005(13). To determine the relationship between the parties, the Board must first apply the "right to control" test. *Woody v. Waibel*, 276 Or 189, 196, 554 P2d 492 (1976). If the relationship cannot be determined under that test, it is permissible to apply the "relative nature of the work" test. *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, **<129 Or App 474/475>** 622 n 6, 872 P2d 1 (1994) (citing *Woody v. Waibel, supra*, 276 Or at 197-98).[2] Here, the Board held that the traditional right to control test was inconclusive. It then applied the relative nature of the work test and concluded that claimant was a worker. SAIF argues that because the right to control test conclusively establishes that claimant was not a worker, the Board erred when it considered the relative nature of the work test.

When the basic facts are not in dispute, as is the case here, the question of employee or independent contractor status is one of law. *Woody v. Waibel, supra*, 276 Or at 192 n 3. Similarly, whether a right to control exists under the facts as found is also a question of law for the court. *HDG Enterprises v. Natl. Council on Comp. Ins.*, 121 Or App 513, 318, 856 P2d 1037 (1993). Under the common law right to control test, the principal factors to be examined 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).

As to the first factor, DIF found that NCE procured the contract with the Japanese schools and determined the total number and age range of the students composing each group. NCE specified the type of host family that claimant could recruit [3] and specified the number of families that had to be signed up by certain dates. NCE required that English classes be taught from a study center to be located by claimant but paid for by NCE. Although claimant used her own ideas in preparing the itinerary, NCE imposed numerous limitations on the schedule of activities.[4] Claimant was required to **<129 Or App 475/476>** submit a finalized budget that accounted for the $28 per student. NCE advised claimant and other TCs how to dress for teaching. Those facts represent direct evidence of NCE's right to control.

DIF also made findings that indicate NCE lacked a right to control. Claimant could recruit any host family that met NCE's specifications, and NCE did not approve or disapprove of any family that met those specifications. Similarly, claimant was free to design the itinerary, which was reviewed by NCE only to verify that it included all the required activities. Claimant paid for all costs associated with recruiting the host families and locating the study center and all expenses above those budgeted to

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[1] The Board also reversed the referee's award of attorney fees to claimant's counsel. Claimant does not seek review of that part of the order.

[2] Because the facts of this case arose before October, 1989, we do not consider the 1989 statutory amendments at issue in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra*, 318 Or at 622.

[3] NCE required the "families" to consist of two related people, one of whom is a native English speaker, who speak English as their primary language while the student is in the home.

[4] Claimant had to teach English three hours a day, four days a week. She had to provide one full-day excursion per week, the first of which had to be to the nearest major city. Only one of the full-day excursions could last for nine hours instead of seven. The half-day outings had to be away from the study center and had to last for three hours each. The cultural exchanges were for three hours and had to include American and foreign students. The sports afternoons were also limited to three hours each.

implement the itinerary. Finally, the contract between NCE and claimant stated that claimant performed work under the contract as an independent contractor. While the parties' understanding of their relationship is not controlling, in a close case, it may swing the balance toward status as an independent contractor. *Woody v. Waibel, supra*, 276 Or at 198-99; *Henn v. SAIF*, 60 Or App 587, 592, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983).

As to the second factor, method of payment, NCE paid claimant $325 per week plus $50 for each host family that she recruited. Payment was made in three lump sums. Payment by a unit of time is strong evidence of employee status. 1B Larson, *Workmen's Compensation Law* 8-107, 44.33(a) (1993). However, when payment is by quantity, the method of payment factor becomes neutral. *Henn v. SAIF, supra*, 60 Or App at 592. Because claimant was paid both by time and by quantity, this factor is inconclusive.

The third factor, the furnishing of equipment, is neutral. NCE paid for the use of the study center, provided a *Modern Homestay English* textbook to claimant and to each student, and budgeted for classroom expenses. Claimant was not required to use the provided textbook, although she chose to do so. Claimant used her own phone and car, without reimbursement from NCE, to locate the host families and to locate the study center. As to the final factor, the contract indicates that NCE did not have the right to fire claimant. This factor indicates independent contractor status.

129 Or App 477> Based on the evidence, we hold that the Board correctly concluded that the right to control test was not determinative of relationship between claimant and NCE. Consequently, the Board acted properly by applying the relative nature of the work test. NCE does not argue that the Board erred in its application of that test. Accordingly, the Board did not err in concluding that claimant was a subject worker.

Claimant assigns error to the Board's conclusion that she was injured while engaged in a recreational activity primarily for her personal pleasure and that, as a consequence, her injury is not compensable. An accidental injury is compensable if it arises out of and in the course of employment. ORS 656.005(7)(a). Under ORS 656.005(7)(b)(B), however, an accidental injury is not compensable if it is incurred during "any recreational or social activities primarily for the worker's personal pleasure."[5] In its order, the Board concluded that claimant's injury was not compensable because "riding the bumper cars did not have a close work nexus and was performed 'primarily' for claimant's own pleasure."

We conclude that the Board's legal conclusion that claimant's injury was noncompensable under ORS 656.005(7)(b)(B) is not supported by its findings. Central to the Board's analysis is its finding that the activity was an optional part of the program. In deciding that the activity was not sufficiently work-connected, the Board considered as critical the fact that this was an optional, as opposed to a budgeted, activity. We do not believe that this distinction is as determinative as the Board apparently believed. As the Board found, NCE required claimant to list all budgeted activities on the "CHI Itinerary form" and all optional activities on the "CHI Optional Activity form." Accordingly, NCE knew that the students would be participating in the optional activities while at the park and under claimant's supervision. Although the activities were "optional" for the students, claimant's continuing role as a supervisor was not optional. As the Board found, NCE required claimant to be with the students *at all times while at the park* and that her primary function while **<129 Or App 477/478>** there was to supervise those students. Claimant had those responsibilities regardless of whether the students were participating in a budgeted or optional activity. Furthermore, because NCE did not question claimant's ability to perform her supervisory duties while she participated in the budgeted activity, there is no reason to assume that she could not similarly perform those duties while she participated in the optional activities. Consequently, we see no meaningful distinction between claimant's supervisory role during the roller-skating activity and during other "optional" carnival rides.

The Board also based its conclusion on its finding that claimant had fun on the carnival ride. However, we do not think that whether claimant had fun while participating in the activity should be determinative of whether her injury was related to her work. The proper inquiry under ORS 656.005(7)(b)(B) is, what is the primary purpose of the activity? The fact that a worker derives pleasure *from* a work activity does not necessarily mean that the worker engages in the activity primarily *for*

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[5] We express no opinion as to whether the phrase "recreational activities," as used in ORS 656.005(7)(b)(B), includes activities that are part of a worker's regular employment.

personal pleasure. It would be absurd to make the compensability of an injury turn on whether a worker has fun doing his or her job. Under the Board's analysis, claimant's injury in this case might have been compensable had she testified that she hated carnival rides. We thus conclude that claimant is not precluded by ORS 656.005(7)(b)(B) from establishing a compensable injury.

Even though ORS 656.005(7)(b)(B) does not preclude claimant from establishing the compensability of her injury, we must still determine if the injury is compensable under ORS 656.005(7)(a). To do so, we apply the unitary work-connection test. Under that analysis, we consider whether the injury arose out of and whether it was in the course of claimant's employment. These two factors are part of a single inquiry: Is the relationship between the injury and the employment sufficient that the injury should be compensable? *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994); *Rogers v. SAIF*, 289 Or 633, 642, 616 P2d 485 (1980). Both factors must be evaluated to determine work connection. *Norpac Foods, Inc. v. Gilmore, supra*, 318 Or at 366. Neither factor is dispositive, and deficiencies in the **<129 Or App 478/479>** strength of one factor may be made up by the strength of the other.[6] *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983).

We must first examine whether the injury occurred in the course of employment. To do so, we consider the time, place and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore, supra*, 318 Or at 366. Because NCE required that claimant be with the students until the time that they left the park, the injury occurred during work hours. The injury occurred at the amusement park, the general place where claimant was required to be. As discussed above, she was required to supervise the students whether they were engaged in a budgeted or optional activity. She was, in fact, with eight or nine of the students at the time of her injury. We do not think that the fact that she actually participated in the ride with the students was sufficient to take her activity outside the course of her employment. We conclude that claimant's injury occurred in the course of her employment.

We must next determine whether the "arising out of" element of the work-connection test is satisfied. This element concerns the causal connection between the injury and the employment. *Norpac Foods, Inc. v. Gilmore, supra*, 318 Or at 366. In assessing this connection, we consider whether what occurred was an anticipated risk of employment. *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 338, 874 P2d 76 (1994). As explained by Larson, and quoted with approval by the Supreme Court in *Phil A. Livesley Co. v. Russ, supra*, 296 Or at 29:

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks -- i.e., risks having no particular employment or personal character. * * * It is within the third category that **<129 Or App 479/480>** most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." 1 Larson, *supra*, at 3-12.

We conclude that, based on the facts found by the Board, claimant's injury arose out of her employment. NCE's knowledge that the students might be riding the bumper cars while at the park, its requirement that claimant stay with the students and supervise them until they left the park and its acceptance of claimant's participation with the students in another park activity show that claimant's employment put her in a position to be injured.

Claimant's injury arose out of and in the course of her employment and, therefore, was compensable. ORS 656.005(7)(a). The Board erred in reversing the referee's order on the issue of compensability.

Reversed and remanded on petition; affirmed on cross-petition.

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[6] The Board concluded that "claimant's finger condition did not arise out of and in the course of her employment." However, despite its reference to the unitary work-connection test, the Board did not apply the Supreme Court's methodology for determining compensability. After ostensibly analyzing the facts under ORS 656.005(7)(b)(B), the Board stated:

> "Moreover, if we analyze claimant's injury under the unitary work-connection test, we are also persuaded that there was not a sufficient benefit to the employer to find a work connection between an injury occurring during this carnival ride and claimant's employment."

Cite as 129 Or App 494 (1994) August 10, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Adam Berkey, Claimant.

NOAH **BERKEY**, Petitioner - Cross-Respondent,
v.
DEPARTMENT OF INSURANCE AND FINANCE, SAIF CORPORATION and ADAM BERKEY,
Respondents - Cross-Petitioners - Cross-Respondents.
(WCB 90-19924; CA A78975)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs January 14, 1994.
Noah Berkey filed the brief pro se for petitioner - cross-respondent.
Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and John T. Bagg, Assistant Attorney General, filed the brief for respondents - cross-petitioners - cross-respondents Department of Insurance and Finance and SAIF Corporation.
Kimberley Chaput and Pozzi Wilson & Atchison filed the brief for respondent - cross-petitioner - cross-respondent Adam Berkey.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Affirmed on petition; affirmed on cross-petition of Department of Insurance and Finance and SAIF Corporation; on cross-petition of Adam Berkey reversed and remanded for reconsideration of non-compliance issue and otherwise affirmed.

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129 Or App 496> Petitioner Noah Berkey (Noah) and cross-petitioners, Department of Insurance and Finance (DIF), and SAIF Corporation, seek review of a Workers' Compensation Board order holding that claimant Adam Berkey (Adam) is an Oregon subject worker and that Noah was a non-complying employer. In his cross-petition, Adam assigns error to the Board's failure to find that Noah was non-complying and to the Board's denial of penalties against SAIF.

Noah is a contractor, registered in Oregon. He does business as Berkey Pole Buildings. His principal business is building pole barns in Oregon, although he occasionally builds pole barns out of state. Adam, who is Noah's son, worked for Noah sporadically for several years. Noah has never carried workers' compensation insurance.

In 1990, Noah entered into a written contract to build a pole barn on a California ranch. Payment was made to Berkey Pole Buildings. Noah and an older son, Cliff, orally agreed that Cliff would build the barn. Cliff carried no workers' compensation insurance. Noah drove Adam to California so Adam could work with Cliff on the barn. While working on the barn in September 1990, Adam fell from a truss and was seriously injured.

The procedural facts are complex, and we recite only those necessary to our holding. Adam's guardians filed a workers' compensation claim on his behalf. DIF initially issued an order of noncompliance. It referred the claim to SAIF for processing under OAR 436-80-060(2) as it read in 1990. However, DIF later received information that persuaded it that Adam was not a subject worker, so DIF rescinded its order of noncompliance. DIF asked SAIF to deny the claim, and SAIF did so. Adam then requested a hearing.

The hearing convened on December 20, 1990. SAIF waived appearance. DIF appeared to defend its rescission of its order of noncompliance. Adam objected to DIF's participation on the ground that SAIF was the real party in interest. The referee overruled that objection and issued an interim order referring the claim back to DIF so that DIF could issue a non-compliance order. DIF did not issue the order of non-compliance. Because DIF did not issue the order of non-compliance, **<129 Or App 496/497>** SAIF never processed the claim or authorized benefits for Adam.

Adam then requested a hearing on SAIF's *de facto* denial of benefits. That hearing was held May 13, 1991, and incorporated the record of the December 20, 1990, hearing. Noah and Adam appeared.

At the hearing, the referee dismissed DIF as a party. Adam testified at the May 13, 1991 hearing, but the referee refused to let him answer some of Noah's questions because he was under a guardianship. Because DIF was no longer a party, it could not cross-examine Adam. On June 7, 1991, DIF moved for reconsideration of the May 13 order dismissing it as a party. The referee granted that motion.

On July 12, 1991, the referee withdrew the interim order referring the claim back to DIF and held that the October 17, 1990, denial and request for a hearing placed justiciable issues before her. She also concluded that Adam was a subject Oregon worker at the time of his injury; that the injury occurred within the course and scope of his employment; that Cliff was not an independent contractor; that Noah was Adam's employer; and that even if Cliff had been an independent contractor and Adam's employer, Noah was nonetheless responsible for obtaining worker's compensation coverage pursuant to ORS 656.029. She awarded Adam penalties and attorney fees.

On review, the Board adopted and supplemented the referee's findings. Treating DIF's objection to its dismissal as a party as a motion for remand, the Board concluded that a letter written by DIF waived its rights to object.[1] DIF's letter stated, in part, that DIF was "content to stand on the factual record developed prior to that time as a basis for the referee's ruling." The Board adopted the part of the referee's order that Adam was a subject worker but determined that the claim was not properly before SAIF, because DIF had not issued an order finding Noah to be non-complying. The Board affirmed the award of attorney fees but reversed the award of penalties.

129 Or App 498> We first address whether Adam was a subject worker. Noah and DIF assert that the Board's order is not supported by substantial evidence. We review for substantial evidence and errors of law. ORS 183.482(7).

A subject worker employed in Oregon who temporarily leaves Oregon incidental to that employment and is injured on the job is entitled to the same benefits as though the worker had been injured in Oregon. ORS 656.126(1). To determine whether a worker has temporarily left Oregon incidental to Oregon employment, we have applied a permanent employment relation test. *See Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186, 830 P2d 627 (1992). The test for permanent employment looks at a number of factors:

(1) the intent of the employer;

(2) the understanding of the employee;

(3) the location of the employer and its facilities;

(4) the circumstances surrounding the work assignment;

(5) the state laws and regulations to which the employer is subject; and

(6) the residence of the employees.

No one fact is determinative. 113 Or App at 189.

The referee and the Board found that Noah's work force was primarily composed of his sons; that Adam had worked for Noah intermittently for several years; and that, while Adam was living in Utah, Noah told him he could return to his hometown in Oregon and work for Berkey Pole Buildings. Those facts support the Board's conclusion that Noah intended and Adam understood that Adam would work for Noah in Oregon in the future. It is undisputed that Adam is an Oregon resident, that Berkey Pole Buildings' facilities are in Oregon and that most of its business is conducted in Oregon. The Board accepted the referee's finding that Noah asked Adam to help build the pole barn in California and drove him to the job site. The circumstances surrounding Adam's assignment in California also support the Board's conclusion that Adam's work in California was temporary **<129 Or App 498/499>** and incidental to permanent employment with Noah in Oregon. We conclude that Adam was a subject Oregon worker under ORS 656.126(1).

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[1] The letter, dated June 13, 1991, was written to the referee concerning DIF's motion for reconsideration.

DIF and Noah next assign error to the Board's conclusion that Noah employed Adam. They argue that, because Noah's son Cliff was an independent contractor who hired and supervised Adam, there was no employment relationship between Adam and Noah. Even if we were to accept the assertion that Cliff was an independent contractor who hired and supervised Adam, Noah would still be ultimately responsible for providing Adam's coverage.

ORS 656.029(1) provides, in part:

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation coverage for all individuals * * * who perform labor under the contract unless the person to whom the contract is awarded provides such coverage to those individuals before labor under the contract commences."

Noah awarded the contract to build the pole barn to Cliff. Building pole barns is a normal and customary part of Noah's business. Cliff did not provide workers' compensation coverage to Adam before labor under the contract commenced. Therefore, Noah was responsible for providing coverage to Adam. There was no error in the Board's conclusion that Noah was responsible for providing workers' compensation coverage for Adam.

DIF next assigns error to the Board's conclusion that DIF waived its right to object to evidence following DIF's removal from the proceeding before the referee. It argues that the Board should have remanded to the referee so Adam could be fully examined. The Board did not err in refusing to remand on these facts. Although DIF was improperly dismissed as a party near the end of the proceedings, DIF waived its objection when it stated that it was "content to stand on the factual record developed prior to that time as a basis for the referee's ruling." The findings made by the referee and adopted by the Board were taken from the record "developed" before DIF's dismissal. Thus, the findings were properly developed so as to preclude remand under ORS <129 Or App 499/500> 656.295(5). The Board correctly held that ORS 656.295(5) did not require a remand.

In his cross-petition, Adam makes two assignments of error. He first assigns error to the Board's failure to find that Noah was a non-complying employer even after it found that Adam was a subject worker. The Board acknowledged that its holding of subjectivity had a preclusive effect on Noah's non-compliance, but apparently thought that it lacked authority to decide the non-compliance issue. The Board could and should have decided the issue of non-compliance. *Colclasure v. Washington County School District*, 317 Or 526, 535, 857 P2d 126 (1993). We remand the case for a determination of non-compliance.

Adam next assigns error to the Board's refusal to assess a penalty against SAIF for an unreasonable denial. Adam argues that SAIF and DIF had no legitimate doubt that the claim was compensable. We review for errors of law and exaimine whether the Board applied the correct legal standard. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591, 763 P2d 408 (1988). Applying this standard to these facts, there was a legitimate controversy concerning Adam's satisfaction of the permanent employment relation test under ORS 656.126(1) and *Northwest Greentree, Inc. v. Cervantes-Ochoa, supra*, 113 Or App at 188. There was no error in the Board's refusal to assess penalties against SAIF.

DIF and Noah make a number of arguments concerning the referee's credibility findings. We have considered those arguments and reject them.

Affirmed on petition; affirmed on cross-petition of Department of Insurance and Finance and SAIF Corporation; on cross-petition of Adam Berkey reversed and remanded for reconsideration of non-compliance issue and otherwise affirmed.

Cite as 129 Or App 547 (1994) August 10, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, Petitioner,
v.
BELLET CONSTRUCTION, Respondent.
(SH-91282; CA A80977)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 1, 1994.
Michael C. Livingston, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Andrew G. Lewis argued the cause for respondent. With him on the brief was Hershner, Hunter, Moulton, Andrews & Neill.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
DE MUNIZ, J.
Reversed and remanded with instructions to reinstate Citation No. C5730-094-91.

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129 Or App 549> Petitioner Occupational Safety and Health Division (OSHD) seeks review of an order of the Workers' Compensation Board[1] holding that employer did not violate safety rules adopted by the Department of Insurance and Finance (DIF),[2] pursuant to the Oregon Safe Employment Act. We review for errors of law, ORS 183.482(8), and reverse.

On June 14, 1991, an OSHD safety compliance officer inspected employer's worksite where a large metal roof was under construction. The officer cited employer for not complying with OAR 437-03-040(1), which provides:

> "All employees shall be protected from fall hazards when working on unguarded surfaces more than 10 feet above a lower level or at any height above dangerous equipment, except when connecting steel beams as stipulated in OAR 437-03-040(2)."

The officer saw four employees on the roof, which was 28 feet above the concrete surface. Two of the employees were walking on beams and cross beams without being attached to a safety line. The officer assessed employer a $2,000 fine, which included a penalty for a repeat violation. OAR 437-01-165.

Employer requested a hearing on the citation. The referee found that the workers were not tied to the safety line. The referee concluded, however, that OAR 437-03-040(1) was not violated, because the rule does not specifically require employees to be attached to a safety line; rather, it requires protection from "fall hazards." The referee found that the severity level of falling 24 feet to the concrete below was "death," but reasoned that the working conditions were not hazardous, because the employees were experienced and the compliance officer had delayed his inspection for several days.

OSHD argues that the referee erred, as a matter of law, in concluding that employer did not violate OAR 437-03-040(1). We agree. The rule expressly requires that employees shall be protected from fall hazards when working **<129 Or App 549/550>** on unguarded surfaces more than 10 feet above a lower level. *See, e.g., Oregon Occupational Safety v. Affordable Roofing*, 125 Or App 99, 102, 865 P2d 439 (1993). The legislature has adopted a strong safe-employment policy and requires employers to equip workplaces with reasonably necessary "devices and safeguards." ORS 654.003; ORS 654.010.[3] OAR 437-03-040(1) does not provide, and the legislature did not intend, that an employee's work experience shall constitute a safety device or safeguard.[4] The referee erred in concluding that an

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[1] The referee's order is considered a final order of the Workers' Compensation Board. ORS 654.290(2)(b).

[2] DIF is now the Department of Consumer and Business Services. Or Laws 1993, ch 744, 10.

[3] The authority to establish the fall protection requirements was delegated by the legislature to DIF. ORS 654.025(2); ORS 654.035.

[4] An employee's experience or expertise may be relevant in calculating the level of risk, which affects the penalty amount. OAR 437-01-135(2).

employee's experience, rather than a physical device, provided adequate fall protection.[5]

Employer nonetheless argues that we cannot reinstate the citation, because OAR 437-03-040(1) is unconstitutional under the Fourteenth Amendment to the United States Constitution. Employer explains that the rule violates its rights under the Due Process Clause, because it fails to provide notice of the type of fall protection required. Because employer failed to preserve that argument at the hearing, we do not address it. *Llewellyn v. Board of Chiropractic Examiners*, 318 Or 120, 127, 863 P2d 469 (1993).

Reversed and remanded with instructions to reinstate Citation No. C5730-094-91.

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[5] Employer also contended, and the referee apparently agreed, that because the compliance officer, upon hearing about employer's alleged violation, took several days to investigate at the scene, the compliance officer must have believed that the risk of falling was slight. OAR 437-015-015(12) provides that the primary duties of a compliance officer include identifying safety violations, issuing citations and furnishing information to employers and employees about hazards. *Oregon Occupational Safety v. Redi-Rooter*, 112 Or App 40, 43, 826 P2d 1052 (1992). An officer's subjective assessment of a hazard does not negate the determination that a rule was violated.

Cite as 129 Or App 595 (1994) August 10, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ELLIS FOREST IMPROVEMENTS CO., a corporation, Respondent,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and SAIF CORPORATION, Petitioner.
(91-05-031; CA A76950)

On remand from the Oregon Supreme Court. *Ellis Forest v. Natl. Council on Comp. Ins.*, 319 Or 79, 872 P2d 14 (1994).

Judicial Review from Department of Insurance and Finance.

Submitted on remand June 13, 1994.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Roland A. Johnson and Walton, Nilsen, Walker & Johnson, P.C., filed the brief for respondent.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

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129 Or App 596> SAIF sought review of a Department of Insurance and Finance (DIF)[1] amended final order requiring it to rebill Ellis Forest Improvement Co., deleting charges for additional workers' compensation premiums. We affirmed without opinion, *Ellis Forest Improvements Co. v. NCCI*, 123 Or App 359, 859 P2d 1208 (1993). On review, the Supreme Court vacated our decision and remanded to us for reconsideration in light of *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994). *Ellis Forest v. Natl. Council on Comp. Ins.*, 319 Or 79, 872 P2d 14 (1994).

We hold that DIF erred in concluding that B. Ellis was a nonsubject worker based on the exemption in ORS 656.027(7). *Parker Furniture v. Natl. Council on Comp. Ins.*, 128 Or App 466, ___ P2d ___ (1994).

Reversed and remanded for reconsideration.

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[1] DIF has since been renamed the Department of Consumer and Business Services. *See* ORS 656.005(9).

Cite as 129 Or App 621 (1994) August 24, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

HELEN JEAN **KRUSHWITZ**, Personal Representative of the Estate of Matthew Allen Theurer, Appellant,
v.
McDONALD'S RESTAURANTS OF OREGON, INC., an Oregon corporation, Respondent, and McDONALD'S CORPORATION, a Delaware corporation, Defendant.
(9104-02047; CA A73926)

Appeal from Circuit Court, Multnomah County.
Ancer L. Haggerty, Judge.
Argued and submitted November 22, 1993.
Kathryn H. Clarke argued the cause and filed the briefs for appellants. With her on appellant's reply brief was Maureen Leonard.
I. Franklin Hunsaker argued the cause for respondent. With him on the brief were Douglas G. Houser, Ronald G. Stephenson, Ronald J. Clark and Bullivant, Houser, Bailey, Pendergrass & Hoffman.
Before Deits, Presiding Judge, and Richardson, Chief Judge,* and Riggs, Judge.
DEITS, P.J.
Affirmed.
*Richardson, C.J., *vice* Durham, J.

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129 Or App 623> Plaintiff, the personal representative of the estate of decedent Theurer, brought this wrongful death action against Theurer's employer, defendant McDonald's Restaurants.[1] The thrust of plaintiff's allegations is that defendant was negligent in allowing the young decedent to work long hours and then drive. As a result, he drove his vehicle on the way home from work without adequate rest, fell asleep at the wheel and was killed in an accident. Defendant moved to dismiss the action on the ground that it is immune from the tort claim and that plaintiff's exclusive remedy is under the Workers' Compensation Law. The trial court granted the motion. Plaintiff appeals, and we affirm.

ORS 656.018 provides, in pertinent part:

> "(1) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability *arising out of compensable injuries* to the subject workers * * *.
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker for *compensable injuries* under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 and 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury." (Emphasis supplied.)

ORS 656.005(7)(a) defines "compensable injury" as one "arising out of and in the course of employment."

Defendant argued to the trial court that ORS 656.018 immunizes it for two reasons. First, it contends that the statute applies "because the alleged negligence of [defendant] was based solely on the employer-employee relationship between [defendant] and Theurer." Second, defendant asserts that the fatal injury itself is compensable under the Workers' Compensation Law, because Theurer was on a "special errand" for defendant at the time of the accident, and was thus excepted from the "going and coming" rule, **<129 Or App 623/624>** under which injuries sustained by employees on the way to or from work are generally not compensable. The trial court agreed with the first argument, disagreed with the second, and granted the motion.

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[1] McDonald's Corporation is also a defendant, but it is not a party to this appeal, which involves only the ORCP 67B judgment in favor of McDonald's Restaurants. We use the term "defendant" to refer only to the latter.

Although plaintiff's argument is more elaborately stated, it depends on a simple contention: The trial court held that Theurer was not on a special errand; he was accordingly within the going and coming rule; therefore, his death does not meet the "compensable injury" condition for immunity or exclusivity under ORS 656.018.

We recently addressed a similar argument in *Errand v. Cascade Steel Rolling Mills, Inc.*, 126 Or App 450, 869 P2d 358, *rev allowed* 319 Or 80 (1994). The plaintiff there filed a workers' compensation claim, contending that his employment was the major contributing cause of a respiratory condition. The Workers' Compensation Board ruled against him, and the plaintiff then brought an action in circuit court, seeking damages against the employer for the same condition. The trial court granted summary judgment for the employer, on the ground that ORS 656.018 barred the action.

The plaintiff appealed. We summarized his contention:

> "The gist of plaintiff's argument is that, because his condition does not entitle him to benefits under the Workers' Compensation Law, he may seek civil damages outside of the workers' compensation system." 126 Or App at 453.

We rejected that argument, explaining:

> "The exclusivity of the Act is not limited to claims that are ultimately determined to be compensable. As the Supreme Court said in *Reynolds et al v. Harbert et al*, 232 Or 586, 591, 275 P2d 245 (1962),
>
> > "'the statutory scheme was intended to provide that a workman covered by Chapter 656 must accept the benefits thereof as his exclusive remedy * * *.' (Emphasis supplied.)
>
> "Despite the changes to ORS chapter 656 since 1962, the policy behind the Supreme Court's decision in Reynolds remains the same. If the employer and the worker are subject to the Act, then the Act provides the worker's exclusive **<129 Or App 624/625>** remedy for work-related injuries. If, under the Act, no compensation is available for the work-related injury, then the worker has no other remedy against the employer. *Compare Carr v. U S West Direct Co.*, 98 Or App 30, 35, 779 P2d 154, *rev den* 308 Or 608 (1989) (no causal link shown between injury and risk connected with employment)." 126 Or App at 454.

We also noted:

> "Plaintiff relies on *Hubbard v. Reynolds Metal Company*, 482 F2d 63 (9th Cir 1973), to support his view that a common law or statutory claim may lie for a condition that is not within the 'coverage' of the Act. We would agree with that general proposition, although we would use different words to describe it. 2A Larson, *Workmen's Compensation Law* 12-1, 65 (1993). If, for example, the person is not a subject worker, *see Metcalf v. Case*, 278 Or 629, 565 P2d 736 (1977), or if the injury or condition did not occur in the course of employment, *see Sumnee v. Coe*, 40 Or App 815, 596 P2d 617 (1979), then the person's *claim* is not within the scope of the Act, and the Act cannot be the person's exclusive remedy. Plaintiff's claim is within the Act because he is a subject worker and his condition is alleged to have been caused by his employment." 126 Or App at 454-55. (Emphasis in original.)

Although plaintiff's argument differs from the one in *Errand* in some particulars, it shares the threshold misconception that actual compensation for an injury, rather than the work relationship of the injury, is the relevant consideration. That is the same point that we rejected in *Errand*.

Here, plaintiff's argument goes beyond that point. She asserts that Theurer's fatal injuries were subject to the going and coming rule as a matter of law, and therefore were not incurred "in the course of employment" and are not compensable as a matter of law. Plaintiff cites the definition of "compensable injury" in ORS 656.005(7)(a), and states that the "statute is in the conjunctive: the injury must 1) arise out of, *and 2) in the course of employment.*" (Emphasis plaintiff's.) However, the Supreme Court has rejected that bifurcated application of the statute. In *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), the court explained that the phrases "arising out of" and "in the course of" do not establish distinct tests, and it adopted "a unitary 'work-connection' approach in place of the customary

mechanistic <129 Or App 625/626> two-stage method of analysis." 289 Or at 643. The court proceeded to hold that the death of an employee from a myocardial infarction was compensable because, although the precipitating events and stress fell on a continuum, some related to and some remote from the employee's work, they were on balance "causally related to his work." 289 Or at 644.

In *Cope v. West American Ins. Co.*, 309 Or 232, 785 P2d 1050 (1990), the court applied the unitary work-connection analysis to a claim involving the going and coming rule, and noted that there are many exceptions to the rule. Among them, the court said, is that "if an employee is subjected by reason of her employment to a greater hazard than the general public, an injury sustained while going to work may be compensable." 309 Or at 238.

Most recently, in *Norpac Food, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994), the Supreme Court again addressed the application of the unitary approach in the context of the going and coming rule and the so-called "parking lot" exception. The court said that the "arising out of" prong and the "in the course of" prong must both be considered, with neither being dispositive. The first prong relates to the causal connection of the injury and work, and the second relates to the "time, place and circumstances of the injury." 318 Or at 366.

In this case, however, the causal inquiry and the time, place and circumstances inquiry overlap. Plaintiff's allegations are that Theurer's fatal injuries were caused by defendant's negligence in allowing him to work excessively and then, despite his fatigued condition, in failing to "arrange for alternative transportation for him other than a self-driven automobile." Clearly, those allegations show the necessary causal connection between work and the injury. They also indicate on their face that the necessary time, place and circumstances are present. The effect of the going and coming rule is normally to define travel to and from the worksite as being outside the scope of the time, place and circumstances of employment. *See Norpac Foods, Inc. v. Gilmore, supra*, 318 Or at 366. Correspondingly, the effect of the exceptions to the rule is to extend the work-related time, place and circumstances into what would normally be regarded as simple commuting under the rule itself. *See Henderson v. S.D.* <129 Or App 626/627> *Deacon Corp.*, 127 Or App 333, 874 P2d 76 (1994). The exception that the complaint reveals on its face in this case is the one noted above that the court described in *Cope*: Theurer was subjected by his employment to a greater hazard than the traveling public generally confronts, and the hazard persisted throughout and excepted the entire trip from the going and coming rule. The same alleged negligence by the employer that caused the injury also made the drive hazardous, took it outside the going and coming rule and brought it within the time, place and circumstances of Theurer's employment. Therefore, plaintiff's allegations themselves disclose that there is sufficient connection here to show, under both the "arising out of" and the "in the course of" parts of the test, that the injury was compensable within the meaning of ORS 656.018. The trial court was correct in concluding that the action is barred by the statute.

Plaintiff next argues that the trial court's ruling deprived her of a remedy and conferred an unequal privilege on defendant, in violation of Article I, sections 10 and 20, of the state constitution. Plaintiff does not question that the statute may create an exclusive remedy and bar civil actions. However, she contends that the trial court's application of the statute goes beyond that and "provide[s] a bar where it does not provide a remedy." However, we have concluded that Theurer's death, under the facts plaintiff alleges, is compensable within the meaning of ORS 656.018, as the Supreme Court and we have interpreted it. Accordingly, the premise of plaintiff's constitutional arguments disappears.[2]

Plaintiff's remaining argument is that defendant took an inconsistent position in related litigation from the one it takes here, and should therefore be estopped from relying on its present arguments. Plaintiff's arguments in this appeal do not demonstrate an inconsistency.[3]

Affirmed.

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[2] We do not imply that plaintiff's constitutional arguments might otherwise have merit. *See Neher v. Chartier*, 124 Or App 220, 862 P2d 1307 (1993), *rev'd on other grounds*, 319 Or 417, ___ P2d ___ (1994). We also do not imply that plaintiff could necessarily recover benefits. As in *Errand v. Cascade Steel Rolling Mills, Inc., supra*, considerations that differ from those we have addressed might be dispositive of a workers' compensation claim.

[3] We imply no view concerning the other lawsuit. We decide this issue only on the basis of the merits of plaintiff's argument in this appeal.

Cite as 129 Or App 636 (1994) August 24, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kenneth G. Mize, Claimant.

SAIF CORPORATION and KENNETH G. MIZE, DMD, Petitioners,
v.
KENNETH G. **MIZE**, Respondent.
(92-00725; CA A79278)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 17, 1994.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Jeff J. Carter argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Petition dismissed.

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129 Or App 638> SAIF petitions for judicial review of a Board order holding that, under the "dual capacity doctrine," claimant was a subject worker at the time of his injury. We hold that SAIF is foreclosed from challenging compensability because it has accepted claimant's claim and therefore dismiss the petition as moot.

Claimant is a dentist who incorporated his practice in July, 1989, and became a corporate officer with 100 percent ownership. On December 5, 1991, he filed a claim for carpal tunnel syndrome. SAIF denied the claim. The referee set aside SAIF's denial on the basis that ORS 656.027(9), as amended by the legislature in 1990, resembled the statute we interpreted in *Erzen v. SAIF*, 40 Or App 771, 596 P2d 1004, *rev den* 287 Or 507 (1979). In that case, we held that a corporate officer who has not elected coverage may nonetheless receive benefits as a covered worker. On March 12, 1993, the Board affirmed the referee.

On March 25, 1993, SAIF sent claimant a "NOTICE OF ACCEPTANCE FOR A DISABLING INJURY" that stated, "Your workers' compensation claim has been accepted." The notice contained information about return to work assistance, amount and frequency of payment, and medical treatment. It informed claimant that SAIF had enrolled him in a managed care organization program and that SAIF was in the process of determining whether claimant's physician, Dr. Buza, was "credentialed" by that organization. The notice did not, in any way, specify that the acceptance was contingent on SAIF's right to appeal.

On April 9, 1993, SAIF petitioned for judicial review of the Board's order. On that same date, SAIF sent claimant a letter stating that its March 25 notice of acceptance "was made contingent upon our right to appeal in this case."

Claimant asserts that SAIF's petition for review should be dismissed, because SAIF accepted his claim on March 25, 1993. SAIF responds that it issued the acceptance notice "so that the claim could be processed" and that "it was not intended to be an acceptance that would terminate SAIF's right to appeal." SAIF does not argue that the notice of **<129 Or App 638/639>** acceptance was not an acceptance or that it was issued by mistake.

SAIF contends, correctly, that whether a claim has been accepted is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454, 832 P2d 1271 (1992). In this case, however, there is no question of fact because SAIF concedes, and the record confirms, that SAIF sent claimant a notice of "acceptance" on March 25, 1993. It did not in the subsequent letter, and does not here, contend that it did not "accept" the claim. Rather, it contends that its acceptance was contingent on its right to seek judicial review of the Board's order. The issue, therefore, is the legal effect of that acceptance with regard to SAIF's right to contest compensability of the claim.

We first address SAIF's argument that it was required by the Board's order to issue the acceptance so that it could process claimant's claim. SAIF cites no authority, and we find none, that *requires* an employer or insurer to issue a written acceptance of a claim after a Board order. To the contrary, where the employer or insurer seeks judicial review within 30 days, ORS 656.313(1)(a) "stays payment of compensation appealed," except for specified temporary and permanent disability benefits.[1] Acceptance of a claim is not required by statute or by rule to process that claim while the compensability issue is being litigated. SAIF's notice of acceptance, stating that it would provide claimant with medical services benefits as well as time loss benefits, was unnecessary, voluntary, and obligated it to provide a greater range of services to claimant than would have been required if the claim had not been accepted.

In *Tattoo v. Barrett Business Service*, 118 Or App 348, 351-52, 847 P2d 872 (1993), we held that employers are bound by the express language of their denials because, holding to the contrary, "an employer could change what it had expressly said in a denial to the detriment of all parties who have relied on the language." We can see no reason why that rule should not apply to an acceptance as well.

129 Or App 640> Here, the acceptance was clear and unqualified. SAIF waited until two weeks *after* the notice of acceptance to inform claimant that its acceptance was contingent on SAIF's right to appeal. Assuming, without deciding, that SAIF could legally issue an acceptance contingent on its right to appeal, the express language of SAIF's acceptance in this case did not do so.[2] To allow an employer or insurer to unilaterally qualify its acceptance after the fact would be detrimental to any party that could have relied on the original acceptance and would undermine the policy objectives of ORS 656.012. Once an employer or insurer officially notifies a claimant that the claim has been accepted, it may not subsequently deny compensability without complying with ORS 656.262(6). *See Johnson v. Spectra Physics*, 303 Or 49, 54-55, 733 P2d 1367 (1987).

We next consider whether SAIF's acceptance of the claim forecloses its right to challenge compensability. ORS 656.262(6) entitles claimants to written notice of claim acceptance or denial and specifies the information that must appear in a notice of acceptance. SAIF does not maintain that the notice it sent to claimant was something other than a notice of acceptance under the statute. Once it accepted claimant's claim, SAIF was no longer in a position adverse to claimant. It was obligated to provide benefits. *See* ORS 656.262(2). Furthermore, after receiving SAIF's acceptance, claimant no longer had a reason to defend the compensability of his claim under the dual capacity doctrine. His right to benefits had been secured, rendering the controversy over compensability moot. To now address the merits of SAIF's petition would be to issue an advisory opinion. Hence, the petition for judicial review must be dismissed.[3]

Petition dismissed.

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[1] SAIF's contention that it was required to issue a notice of acceptance in order to process claimant's Workers' Compensation benefits is also weakened by ORS 656.262(9), which provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim[.]"

[2] We emphasize that our decision does not consider whether an insurer or self-insured employer can properly issue an acceptance that is contingent on its appeal rights.

[3] This decision is consistent with the rule that voluntary satisfaction of a judgment generally forecloses an appeal from the judgment by the satisfying party. *See City of Portland v. One 1973 Chevrolet Corvette*, 113 Or App 469, 470, 833 P2d 1285 (1992). Like the City of Portland in that case, SAIF's failure to use available statutory procedures pending review rendered its conduct voluntary.

Cite as 130 Or App 46 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Albert Huntley, Claimant.

PACIFIC MOTOR TRUCKING, Petitioner,
v.
ALBERT **HUNTLEY**, Respondent.
(Agency No. 92-12551; CA A81851)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 29, 1994.
Kenneth L. Kleinsmith argued the cause for petitioner. With him on the brief was Meyers & Radler.
James L. Edmunson argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz* and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.
*De Muniz, J., *vice* Richardson, C.J.

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130 Or App 48> Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in holding that claimant's hospitalization for pneumonia is compensable and that claimant is entitled to a penalty and attorney fees.

Claimant is permanently and totally disabled as a result of a compensable injury in 1977. His disability renders him paraplegic. In March, 1992, he was admitted to the hospital for a respiratory condition that was diagnosed as pneumonia. He sought reimbursement for his medical bills. Employer denied the claim, contending that the pneumonia and hospitalization were not related to the compensable condition. The Board found that, although the pneumonia was not compensable, the hospitalization was, because it was necessited by claimant's compensable condition, which made claimant unable to care for himself at home during his illness. The Board found, additionally, that employer had unreasonably delayed processing of the claim and assessed a penalty. Because the Board's findings are supported by substantial evidence, claimant prevails.

The Board also awarded claimant an assessed attorney fee pursuant to ORS 656.386(1).[1] Citing our decision in *SAIF v. Allen*, 124 Or App 183, 861 P2d 1018 (1993), *rev allowed* 318 Or 478 (1994), employer argues that, because the only aspect of the claim on which claimant prevails relates to medical services, there is no basis for an award of fees under that statute. If this were a claim for medical services for the original compensable injury, we would agree. Here, however, the disputed medical services were provided for a separate condition and relate to a new claim, the compensability of **<130 Or App 48/49>** which has been the subject of this dispute. Although the pneumonia itself is not compensable, the hospitalization is, because it was necessary as a result of claimant's paraplegia. In the context of this new and separate claim, we conclude that ORS 656.386(1) provides a basis for an assessed attorney fee to claimant for having prevailed on the medical services portion of his claim.

Affirmed.

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[1] ORS 656.386(1) provides:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Cite as 130 Or App 50 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Marie M. Libbett, Claimant.

MARIE M. **LIBBETT**, Petitioner,
v.
ROSEBURG FOREST PRODUCTS, Respondent.
(90-21849; CA A81988)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 17, 1994.
James L. Edmunson argued the cause and filed the brief for petitioner.
Adam T. Stamper argued the cause for respondent. With him on the brief was Cowling & Heysell.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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130 Or App 52> Claimant has a compensable leg injury. The referee determined that claimant is permanently and totally disabled. The Board reversed the referee, holding that claimant had failed to meet her burden of proof. The only question on review is whether the Board erred in relying on surveillance tapes in evaluating claimant's disability and in finding that claimant had not accurately depicted her physical limitations at the hearing or to the doctors who had evaluated the extent of her disability.

ORS 656.245(3)(b)(B) provides, in part:

> "Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

In *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670, 866 P2d 514 (1994), after an examination of the legislative history, we held that the purpose of ORS 656.245(3)(b)(B) is to eliminate Board reliance on *independent medical examinations* for any purpose in its evaluation of a worker's disability. We did not hold, as claimant contends, that the Board is required to *accept* the opinion of the attending physician or that it may not consider other, non-medical, evidence in making its evaluation of the medical evidence or of a claimant's disability. Here, the Board had before it non-medical evidence offered for the purpose of showing that claimant's limitations were not as extensive as she had represented to her physicians or at the hearing. The Board could rely on that evidence in its evaluation of the medical evidence. The Board did not err.

We conclude, additionally, that the Board's finding that it could not give any weight to the vocational expert's opinion because that opinion was based on an inaccurate description of claimant's limitations, is supported by substantial evidence.

Affirmed.

Cite as 130 Or App 81 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John M. Freeman, Claimant.

SAIF CORPORATION and S F & D CORPORATION, Petitioners,
v.
JOHN M. **FREEMAN**, Respondent.
(WCB No. 91-10314; CA A76774)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 18, 1993.
David L. Runner, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Charles Robinowitz argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.
DEITS, P.J.
Affirmed.
*Haselton, J., *vice* Durham, J.

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130 Or App 83> Employer seeks review of an order of the Workers' Compensation Board (Board) setting aside its denial of claimant's current psychological condition. We affirm.

Claimant, who was 53 years old at the time of hearing, was a construction worker who compensably injured his back in May, 1988. As a result of the injury, he was not able to continue to do construction work. Claimant had experienced personality problems before he injured his back; however, he had never sought or received treatment for those problems. In October, 1988, he began seeing Dr. Grass, a psychiatrist. Grass diagnosed depression and prescribed medication and psychotherapy. The treatments were paid for by employer as part of claimant's accepted claim. In April, 1989, the parties stipulated to an award to claimant of 14 percent unscheduled permanent partial disability. In September, 1989, the award was increased to 30 percent. Claimant continued treatment with Grass. In April, 1990, it was Grass's opinion that claimant's psychiatric condition had deteriorated since the determination order was issued and that his claim should be reopened. At employer's request, claimant was examined by psychiatrists in May, 1990, and February, 1991.

In June, 1991, employer issued a denial of claimant's then current psychological condition on the basis that claimant's accepted injury was no longer the major contributing cause of the condition. Claimant requested a hearing on employer's denial and, after the hearing, the referee set aside the denial, concluding that the compensable injury remained the major contributing cause of claimant's current psychological condition. The Board agreed.

Employer seeks review of the Board's order, arguing that it erred in concluding that claimant's compensable injury remained the major contributing cause of claimant's psychological condition. Employer asserts that not only was the Board's legal conclusion wrong, the order was also deficient because the Board failed to adequately explain its conclusion.

It is employer's position that the deterioration of claimant's psychological condition was not caused in major part by his compensable injury, but was caused by claimant's **<130 Or App 83/84>** "conscious desire for additional workers' compensation benefits." Employer characterizes this type of causation as "secondary gains." It describes a "secondary gain" as "an intervening cause that breaks the causal chain between the industrial injury and the psychological condition." Employer contends, relying on our decisions in *Middleton v. SAIF*, 31 Or App 313, 570 P2d 406 (1977), and *Burks v. Western Irrigation*, 36 Or App 587, 586 P2d 788 (1978), that "secondary gains" from an injury cannot result in a compensable condition. It asserts that in those cases, we held that a psychological condition is not a compensable consequence of an injury if it is "caused" by the injury only in the sense that it reflects a conscious or unconscious desire for secondary gains from the injury.

Employer's reading of our holdings in *Middleton* and *Burks* is correct. The circumstances in those cases, however, are distinguishable from those here because, there, the Board found that there was no causal link between the claimant's psychological problems and the compensable condition. In *Middleton v. SAIF, supra*, 31 Or App at 318, for example, the Board found that "claimant's present symptoms and

their intensifications do not flow from his industrial injury, but are caused by an intervening conscious motivation to obtain a permanent and total disability status.'" In contrast, here, the referee and the Board found that there was a sufficient link between the compensable injury and claimant's present psychological condition. The referee explained her conclusion:

> "Dr. Grass explained that claimant became depressed and lost his self esteem and confidence when his ability to produce or work was diminished. I am persuaded that claimant's injury remains the major contributing cause of his current psychological condition. I give greater weight to the opinion of Dr. Grass, claimant's treating psychiatrist, who has treated claimant over a lengthy period of time than to the opinion of Dr. Turco, who only had the opportunity for a brief one-time examination of claimant."

Employer argues that the Board's conclusion was legal error because, in its view, the evidence could only result in the conclusion that claimant's psychological problems were caused by his motivation to obtain more workers' compensation benefits, and that, as a matter of law, cannot support a conclusion that the compensable injury remained **<130 Or App 84/85>** the major contributing cause of those problems. Employer particularly criticizes the Board's reading of the testimony of claimant's treating physician, Grass, which it contends may only be read to support the conclusion that claimant's psychological problems were caused by his desire for more benefits.

Although employer characterizes its argument as one of legal error, in essence it is arguing that there is no evidence to support the Board's conclusion that there was a sufficient link between claimant's injury and his psychological condition. We conclude that there was evidence to support the Board's conclusion that claimant's compensable injury remained the major contributing cause of his condition and that the Board adequately explained its conclusion.

Grass, who was claimant's treating physician, treated claimant at least 36 times between July, 1989, and September, 1991. He testified that he saw claimant for approximately 150 to 200 hours during that time. Although he testified that claimant was upset because he wanted more workers' compensation benefits, Grass also explained why he thought that the pain that resulted from the compensable injury and claimant's inability to return to work were major causes of his depression:

> "Q. How important was his ability to work in construction in maintaining and building his self-confidence in life?
>
> "A. Well, I think it was one of the principal elements in his personality structure. It was what he knew how to do. He was successful at it. It was part of his male identity, and it was what he had seen himself doing for most of his working career, and it was where he knew how to contribute to his family."

Grass further stated:

> "He had a lot of pain, and he'd been evaluated by orthopedists and neurosurgeons and basically said, well, you have injury in your back, but there's nothing we can do to fix it, and you're going to have to learn how to live with this pain. You know, that was very difficult for him. He couldn't go back to work, couldn't do what he knew how to do, and there was no real solution to his injuries, and he was scared that he might not be able to support himself.
>
> "* * * * *
>
> "[Claimant's] been moderately to severely depressed for three years. He hasn't been able to feel secure about whether **<130 Or App 85/86>** he can survive, support himself. The elements that led to that depression have to do with what happened to him in '88. He can't support himself, so he is dependent on this organization, SAIF, to help him with that. He's not a man that feels comfortable with dependency, never has been. That's not his work ethic. That's not his personality. I don't think he likes being enmeshed with this organization any better than any of the rest of us would, but he had to depend on them. He had no other way to earn a living, to support himself. So when that gets jeopardized, yes, that would aggravate his depression. I think it would any of us. We'd get frightened if we didn't know if we could support ourselves. I don't see it as unreasonable."

We hold that the Board did not err in concluding that claimant's injury remained the major contributing cause of his psychological condition.

Affirmed.

Cite as 130 Or App 170 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Mitchell C. Beem, Claimant.

AGRIPAC, INC., and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners - Cross-Respondents,
v.
MITCHELL C. **BEEM**, Respondent - Cross-Petitioner.
(92-04596; CA A82044)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 29, 1994.
Alexander D. Libmann argued the cause for petitioners - cross-respondents. On the briefs was James D. McVittie.
Robert Wollheim argued the cause for respondent - cross- petitioner. With him on the brief were Welch, Bruun, Green & Wollheim, and Tom Cary and Coons, Cole & Cary.
Before Rossman, Presiding Judge, and De Muniz* and Leeson, Judges.
LEESON, J.
Affirmed on petition and on cross-petition.
*De Muniz, J., *vice* Richardson, C.J.

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130 Or App 172> Employer petitions from an order of the Workers' Compensation Board awarding temporary partial disability, and claimant cross-petitions from the same order, contending that the Board erred in failing to make an award of permanent partial disability. We affirm on the petition, and write only to address the cross-petition.

Claimant contends that under ORS 656.245(3)(b)(B), only Dr. Feinberg, his attending physician, could rate his impairment, and that the Board erred in rejecting his opinion and in admitting the opinions of independent medical examiners. Claimant is correct that only the attending physician may rate claimant's impairment and that other medical evidence is not admissible to impeach the attending physician's opinion. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 866 P2d 514 (1994).

We conclude, however, that the Board's error, if any, in admitting other medical evidence is harmless. Assuming, without deciding, that Feinberg qualified as claimant's attending physician under ORS 656.005(12)(b)(B),[1] the Board found that it was unclear whether Feinberg attributed claimant's permanent limitation to his compensable injury or to a subsequent injury, and that therefore Feinberg's opinion did not support a permanent disability award. The Board chose not to accept Feinberg's opinion, which was the only opinion indicating that claimant had permanent impairment. It can do that. *Libbett v. Roseburg Forest Prod.*, 130 Or App 50, ___ P2d ___ (1994).

Affirmed on petition and on cross-petition.

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[1] In considering the findings of Feinberg, the Board noted:

"Dr. Feinberg became claimant's attending physician in October 1989 and continued treating him until February 1991. Dr. Feinberg, a chiropractor, treated claimant at a frequency of four times per month from July 20, 1990 until February 7, 1991. * * * Under such circumstances, Dr. Feinberg likely did not qualify as an attending physician under ORS 656.005(12)(b)(B) by the time of claim closure in October 1991, since his treatment exceeded 30 days or 12 visits from the date of the first visit on the claim."

Cite as 130 Or App 185 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joseph E. Kelly, Claimant.

SAIF CORPORATION and IMAGE GRAPHICS & LITHO, INC., Petitioners,
v.
JOSEPH E. **KELLY**, RIDDLE PRESS and KEMPER INSURANCE CO., Respondents.
(91-06705, 91-05122; CA A79721)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 13, 1993.
Steve Cotton, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Craig A. Staples argued the cause for respondents Riddle Press and Kemper Insurance Co. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
No appearance for respondent Joseph E. Kelly.
Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.
HASELTON, J.
Reversed and remanded for reconsideration.
*Haselton, J., *vice* Durham, J.

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130 Or App 187> SAIF seeks review of an order of the Workers' Compensation Board that applied the last injurious exposure rule to assign SAIF responsibility for claimant's occupational disease. We reverse and remand.

Claimant, a printing press operator, sought treatment for wrist and arm pain in 1988, while employed by an insured of Kemper Insurance Company (Kemper). Claimant's physician, Dr. Gill, diagnosed carpal tunnel syndrome, which the employer accepted. In 1990, Gill performed surgery. Claimant's condition improved, but he continued to experience some pain in his left elbow and right thumb. In January 1991, claimant stopped working for Kemper's insured and began working for an employer insured by SAIF. On February 12, 1991, Gill diagnosed claimant's left elbow and right thumb/wrist[1] condition as de Quervain's tenosynovitis.

Claimant filed claims against both Kemper and SAIF. The referee found:

> "5. Following the surgery, most of claimant's hand and arm symptoms resolved. However, he had continuing symptoms in his left elbow and right thumb. The left elbow symptoms improved, but did not entirely resolve, with therapy.
>
> "6. Claimant continued to work at [Kemper's insured] through January 17, 1991. *During that time, he developed increased left elbow and right wrist/thumb pain.*" (Emphasis supplied.)

The referee concluded that work for Kemper's insured was the major contributing cause of claimant's occupational disease and that Kemper had not made a showing sufficient to shift responsibility to SAIF.

On review, the Board, although adopting the referee's findings in their totality, reversed and assigned responsibility for claimant's condition to SAIF under the last injurious exposure rule. It found:

> **130 Or App 188>** "Claimant first sought treatment for his current left elbow and right wrist de Quervain's tenosynovitis conditions on February 12, 1991, during his employment with SAIF's insured."

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[1] The referee refers to claimant's "right wrist/thumb" condition. The Board refers to claimant's "right wrist de Quervain's tenosynovitis." Those labels appear to be interchangeable.

SAIF petitioned for reconsideration, arguing that the Board improperly relied on the date of diagnosis, rather than the date claimant first sought treatment for symptoms, in assigning responsibility. The Board held on reconsideration:

> "[W]e remain persuaded that February 12, 1991 was the date claimant first actually sought treatment for his current left elbow and right wrist de Quervain's conditions. Our finding in this regard does *not* depend on the fact that Gill diagnosed de Quervain's tenosynovitis on that date. Instead, it is based on the fact that claimant sought treatment on February 12, 1991 and Gill, on that date, first identified claimant's post-[carpal tunnel syndrome] surgery right wrist and left elbow conditions as 'separate' from and 'unrelated' to the prior problems." (Emphasis in original.)

On appeal, SAIF argues that the Board applied the wrong "trigger" for the "last injurious exposure" rule--*i.e.*, that the Board improperly focused on the date of initial diagnosis of claimant's de Quervain's condition and not the date that claimant first sought medical treatment for symptoms of that condition. Kemper does not dispute that the date claimant first sought treatment for symptoms is the correct "trigger." Kemper argues, instead, that the Board did, in fact, base its determination on the correct "trigger" and that substantial evidence supports the Board's finding that claimant first sought treatment for his left elbow and right wrist/thumb symptoms while employed by SAIF's insured.

We agree with SAIF that, in assigning responsibility under the last injurious exposure rule, the dispositive date is the date claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. That accords with prior decisions of our Supreme Court and of this court.[2] We also agree with SAIF that the Board seems to have **<130 Or App 188/189>** relied on a different triggering event. If the Board properly focused on the date of treatment for *symptoms*, we do not understand how its findings support its conclusion. In particular, given the Board's adoption of the referee's findings that claimant's left elbow and right thumb symptoms "continue[d]" following surgery and "increased" while he was still working for Kemper's insured through January 17, 1991, we do not understand how it could have concluded that claimant first sought treatment in February 1991, while employed by SAIF's insured. Moreover, the Board explained on reconsideration that it relied on February 12, 1991, as the triggering date because that was the date on which Gill "first identified claimant's post-[carpal tunnel syndrome] surgery right wrist and left elbow conditions as 'separate' from and 'unrelated' to the prior problems." This statement at least implies that Gill treated claimant's symptoms *before* identifying them as a separate condition. Under the circumstances, we cannot determine whether the Board found that claimant sought medical treatment for *symptoms* of his de Quervain's tenosynovitis while employed by Kemper's insured.

We remand for the Board to apply the standard we have enunciated here or to explain its opinion in light of that standard.

Reversed and remanded for reconsideration.

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[2] In *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), the Supreme Court held that the claimant was disabled at the time breathing difficulties forced her to leave work, even though the condition was not diagnosed until after the claimant began working for a different employer. 293 Or at 244. *Accord United Pacific Ins. v. Harris*, 63 Or App 256, 260, 663 P2d 1307, *rev den* 295 Or 730 (1983). In *SAIF v. Luhrs*, 63 Or App 78, 663 P2d 418 (1983), we held that a misdiagnosis of the claimant's carpal tunnel syndrome did not allow SAIF to shift responsibility to the insurer "on the risk" when the condition was correctly diagnosed. *See also Timm v. Maley*, 125 Or App 396, 401, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994) ("the date that the claimant first began to receive treatment *related* to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim" (emphasis supplied)).

Cite as 130 Or App 190 (1994) September 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of George Hames, Jr., Claimant.

BARRETT BUSINESS SERVICES, Petitioner,
v.
GEORGE **HAMES**, JR., Respondent.
(92-13573; CA A82521)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 22, 1994.
Jaurene R. Judy argued the cause for petitioner. With her on the brief was Terrall & Associates.
Corey B. Smith argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
HASELTON, J.
Affirmed.

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130 Or App 192> Employer seeks review of an order of the Workers' Compensation Board holding that claimant's ulnar nerve condition was compensable as the consequence of a compensable injury. ORS 656.005(7)(a)(A). We affirm.

Claimant suffered a compensable dislocation of his right shoulder when he fell from a ladder scaffold at work. During the course of treatment, claimant's shoulder was replaced in its joint and immobilized; that immobilization was reasonable and necessary given the nature of the injury. As a result of the dislocation and necessary immobilization, claimant developed adhesive capsulitis or "frozen shoulder." The treating orthopedic surgeon prescribed "extremely aggressive" physical therapy to treat the adhesive capsulitis and improve the range of shoulder motion. Again, that treatment was reasonable and necessary. During that therapy, which involved rigorous range of motion exercises of claimant's right shoulder and arm, claimant's right ulnar nerve was injured.[1]

Employer denied the compensability of the ulnar nerve condition, and the referee upheld that denial.[2] The referee found, based on medical testimony, that the physical therapy for the right shoulder condition was the major contributing cause of the ulnar nerve condition. The referee concluded that because the treatment, and not the compensable shoulder injury itself, was the major contributing cause, the ulnar nerve condition was not a compensable consequential condition under ORS 656.005(7)(a)(A).[3]

130 Or App 193> The Board, although adopting the referee's findings of fact, reversed:

> "Based on the medical record, therefore, we find that the *sole* cause of claimant's need for physical therapy was the compensable shoulder injury. Because we have found that the physical therapy was the major contributing cause of the ulnar nerve condition, we conclude that the compensable shoulder injury was the major contributing cause of the ulnar nerve condition. Accordingly, the right ulnar nerve condition is compensable." (Emphasis in original; footnote omitted.)

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[1] There is no suggestion in this record that the degree of force used during physical therapy was excessive or inappropriate.

[2] The referee also upheld the employer's denial of claimant's claim for a mild carpal tunnel condition in his right hand. That denial is not at issue in this appeal.

[3] ORS 656.005(7)(a) reads, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

On appeal, employer argues that there is a fundamental and irreconcilable inconsistency between: (1) the Board's finding that the *treatment* of claimant's compensable shoulder injury was the "sole" cause of his ulnar nerve condition; and (2) its conclusion that claimant's shoulder *injury* was the major contributing cause of the ulnar nerve condition. Invoking *Hicks v. Spectra Physics*, 117 Or App 293, 843 P2d 1009 (1992), and *Kephart v. Green River Lumber*, 118 Or App 76, 846 P2d 428, *rev den* 317 Or 272 (1993), employer contends that the Board erroneously equated consequences of the treatment of a compensable injury with consequences of the compensable injury itself.

We disagree. Where, as here, a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). *Hicks v. Spectra Physics, supra*, and *Kephart v. Green River Lumber, supra*, which did not involve the direct consequences of medical treatment of a compensable injury, are materially distinguishable.

In *Hicks*, we held that where a claimant suffered injuries in an auto accident while returning from treatment for an earlier compensable injury, those new accident-related injuries were not compensable under ORS 656.005(7)(a)(A). In so holding, we reviewed the legislative history of the 1990 amendments to ORS 656.005(7)(a) and concluded that the legislature, in adopting the major contributing cause standard for consequential injuries, intended to restrict the compensability of "injuries that are the result of activities that would not have been undertaken but for the compensable **<130 Or App 193/194>** injury[.]" 117 Or App at 296. *Accord Albany General Hospital v. Gasperino*, 113 Or App 411, 414, 833 P2d 1292 (1992) (condition that arose directly, but belatedly, from the original injury was subject to material contributing cause standard, not major contributing cause standard). We pointed, particularly, to excerpts of the legislative debate expressing a clear desire to nullify our holding in *Fenton v. SAIF*, 87 Or App 78, 741 P2d 517, *rev den* 304 Or 311 (1987), which involved facts nearly identical to those in *Hicks*:

> "We keep the standard for compensability of an industrial injury itself as whether [the] work is a material contributing cause of a given condition, but as to consequential damages we do set up a major contributing cause analysis. And what [that] means is if you have a broken arm, that's industrial. And you're crossing the street on the way to see your doctor, and the doctor's office is right over there, and you're headed across the street, and a car runs you down. Under current law, whatever happened to you in that street is included in workers' comp[ensation]. * * * [It's] considered a consequence of your industrial injury. You got hurt on the way to the doctor. Requiring major contributing cause means that no, being run down crossing the street on the way to the doctor is not covered. That's, to me, the most succinct example of the kind of change we are making there." House Special Session, May 7, 1990, Tape 2, Side A (remarks of Representative Mannix), *quoted* at 117 Or App at 296-97.[4]

In *Kephart v. Green River Lumber, supra*, we applied *Hicks*' rationale to affirm the Board's denial of compensation for a shoulder injury the claimant suffered when he fell from a truck in the course of vocational rehabilitation for a compensable hand injury. As in *Hicks*, the claimant in *Kephart* did **<130 Or App 194/195>** not argue that there was some direct or "proximate" relationship between his compensable condition and the new injury. Rather, he relied solely on pure "but for" causation--*i.e.*, but for the hand injury, he would not have been in vocational rehabilitation and, thus, would not have

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[4] The legislative history includes an even more explicit statement, albeit one not cited in *Hicks*, that ORS 656.005(7)(a)(A) was designed to legislatively overrule *Fenton v. SAIF, supra*:

> "What came to mind to me as I read [ORS 656.005(7)(a)(A)] were the cases, for example, the *Fenton* case. The worker is in a car on the way to a doctor's appointment or physical therapy appointment to be treated for the compensable injury and is in a car wreck. And that was found to be compensable, because but for the fact that the worker was in that car on the way to the doctor appointment. Well, I read this section as saying no, unless the cause of that car wreck was the compensable injured knee slipped on the gas pedal or something. It would split that sort of a problem out unless the major cause for this new second condition, in effect, was the initial accepted condition." Tape recording, Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side A at 240 (comments of Constance Wold, Insurance Defense Attorney).

fallen from the truck and hurt his shoulder. We held that such "but for" causation did not render the hand injury compensable under ORS 656.005(7)(a)(A); the fall from the truck, not the compensable hand injury, was the major contributing cause of the shoulder injury.[5]

This case differs from *Hicks* and *Kephart* in two significant respects. First, the causal relationship between the original injury and the consequential injury here is qualitatively different from the "but for" causation in those cases. Claimant's ulnar nerve injury was not the result of some capricious intervening event; instead, it flowed directly and inexorably from the shoulder injury. The Board's findings, which are not challenged on review, establish that: Once claimant's shoulder was dislocated, it had to be immobilized; once the shoulder was immobilized, adhesive capsulitis invariably developed; once adhesive capsulitis developed, physical therapy was necessary to restore shoulder and arm movement; and once appropriate physical therapy was employed, claimant's ulnar nerve was injured. Once claimant's shoulder was hurt, there was a certain, almost tragic, inevitability to what followed. There were no careening drivers or falls from logging trucks, just the direct consequences of treatment of the compensable injury.[6]

Second, the 1990 Special Session legislative history pertaining to the compensability of medical treatment injuries is, albeit limited, very different from that underlying our analysis in *Hicks* and *Kephart*. Before 1990, we and our Supreme Court had routinely held that new injuries incurred during medical treatment of compensable injuries were **<130 Or App 195/196>** themselves compensable. *See, e.g., Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985); *McDonough v. National Hosp. Ass'n*, 134 Or 451, 461, 294 P 351 (1930). *Accord Wood v. SAIF, supra* n 5, 30 Or App at 1108-1109 (in dicta, reviewing medical treatment cases from other jurisdictions). It might reasonably be expected that if the legislature intended to nullify that well-established authority, the legislative history would include some discussion akin to its disapproval of *Fenton v. SAIF, supra*. But there is none. Instead, the only limited reference to medical treatment injuries in the legislative history suggests an intent to treat such injuries very differently from those suffered in *Fenton*-like "but for" causation cases:

> "This [ORS 656.005(7)(a)(A)] applies only to what are called natural consequences cases. *You trip over your crutches and you break your leg.* That's a direct and natural consequence. You develop a depression condition because you're out of work because you have a bad back. That is the main cause of your subsequent depression. But if that depression also develops at the same time you underwent a divorce or your mother died or something, unless the people that you're treating with it's the psychiatrist that say the major contributing cause was the fact you are out of work, that psych condition will not come into the workers' comp system." Tape recording, Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 272 (statement of Jerry Keene, Workers' Compensation defense attorney). (Emphasis supplied.)

The "trip over your crutches" illustration is closely analogous to this case. In each instance, the claimant was injured as a direct result of pursuing a reasonable and necessary course of treatment--there, crutches; here, physical therapy--for his compensable injury. Indeed, this case is stronger than Keene's illustration because, although someone may trip over crutches for a variety of reasons, the rigorous exercising of claimant's arm and shoulder was an integral part of his treatment.

We conclude that where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial. In such instances, the **<130 Or App 196/197>** compensable injury itself is properly deemed the "major contributing cause of the consequential condition." ORS 656.005(7)(a)(A).

Affirmed.

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[5] *Kephart*, like *Hicks*, represented a reversal of pre-1990 authority. *See Wood v. SAIF*, 30 Or App 1103, 569 P2d 648 (1977), *rev den* 282 Or 189 (1978) (new injuries suffered during vocational rehabilitation training were compensable as consequence of original injury).

[6] At some level, the causation in this case is also "but for" causation--*i.e.*, but for the shoulder injury, claimant would not have required treatment. However, that sort of "but for" causation always exists in cases of direct or "proximate" causation.

Cite as 130 Or App 216 (1994) September 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Stephen R. Rapaich, Claimant.

SAIF CORPORATION, Petitioner,
v.
STEPHEN R. **RAPAICH** and GRAYS INT'L OF OREGON, Respondents.
(92-14281; CA A81722)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 18, 1994.
Steve Cotton, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Robert L. Ackerman argued the cause for respondent Stephen R. Rapaich. With him on the brief was Ackerman, DeWenter & Huntsberger, P.C.
No appearance by respondent Grays Int'l of Oregon.
Before Warren, Presiding Judge, and Edmonds and Leeson, Judges.
WARREN, P.J.
Affirmed.
Edmonds, J., dissenting.

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130 Or App 218> SAIF seeks review of an order of the Workers' Compensation Board that awarded 54 percent permanent partial disability and awarded an out-of-compensation attorney fee. We affirm.

Claimant injured his finger at work. The claim was closed and a determination order awarded scheduled permanent partial disability (PPD). SAIF paid the full award to claimant. On reconsideration, the Department of Insurance and Finance reduced the award to 47 percent. Claimant requested a hearing on the reconsideration order. The Board ordered an increase in claimant's award to 54 percent. The order also provided for an attorney fee of 25 percent of the increased compensation, pursuant to ORS 656.386(2).

SAIF seeks review of the Board's order. Its assignment is that "[t]he Board erred in ordering SAIF to pay an out-of-compensation attorney fee in addition to the PPD award already paid in full to claimant." The order provided, in part:

> "1. Claimant's award of scheduled permanent partial disability is * * * 54 percent loss of the left index.
>
> "2. Claimant's agreement with his attorney is approved for payment of a fee of 25 percent of the increased compensation payable under this order."

On its face, the order approves only an out-of-compensation attorney fee.[1] It does not provide for an

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[1] Paragraph 5 of the Board's order provides:

> "SAIF Corporation shall pay to claimant's attorney * * * an out-of-compensation fee equal to 25 percent of the increased time loss benefits pursuant to this order."

That part of the order requires SAIF to pay an out-of-compensation fee to be paid from time loss benefits. It is not the subject of the assignment of error.

attorney fee in addition to compensation to be paid by SAIF. Given those circumstances, SAIF's assignment of error presents nothing for us to review.[2]

130 Or App 219> Affirmed.

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[2] If SAIF means to argue that OAR 438-15-085 may prevent it from recouping any amount that it is required to pay in addition to compensation, that issue is premature and we need not address it. SAIF has not been ordered to pay attorney fees in addition to compensation, therefore, any potential recoupment of an overpayment is not before us at this time. Further, it is not at all clear whether SAIF will be ordered to pay the attorney fee in addition to the compensation that it has paid. In *SAIF v. O'Neal*, 45 Van Natta 2081 (1993), which is pending review in this court (CA A81987), the employer was ordered to pay the attorney fee in addition to the compensation already paid. However, in *Jane A. Volk*, 46 Van Natta 681 (1994), also pending review in this court (CA A84509), the Board established a procedure by which a claimant's attorney could seek recovery of the fee directly from the claimant when the employer had already paid the entire award before being ordered to pay an out-of-compensation attorney fee. The Board distinguished the situation, such as in *SAIF v. O'Neal, supra*, where the employer had bypassed the claimant's attorney and paid disputed compensation directly to the claimant, thereby depriving the attorney of the opportunity to collect the fee directly from the employer. In light of the Board's distinction based on the facts of the particular case, and because the order before us does not address the question of how the fee will be paid in this case, we will not address arguments about that issue on this review.

EDMONDS, J., dissenting.

The majority fails to recognize what SAIF claims for the import of the Board's order in this case when it holds that SAIF's assignment of error provides nothing for us to review. I would remand this matter to the Board.

To understand SAIF's arguments, it is necessary to keep in mind what occurred before the Board's order. Claimant compensably injured his left index finger. Initially, the Department of Insurance and Finance (DIF) closed the claim with an award of 81 percent scheduled permanent partial disability (PPD) for his index finger. SAIF paid the award. Claimant requested reconsideration by DIF, and on reconsideration, DIF reduced the award to 47 percent. SAIF then audited the file and determined that the reduction in PPD and the increase in temporary total disability (TTD) resulted in an overpayment to claimant of $716.41.

Claimant subsequently appealed the reduction of the 81 percent PPD to 47 percent PPD to the hearings division. The referee granted an award of 54 percent PPD and awarded claimant's attorney "a fee of 25 percent of the increased compensation payable under this order." SAIF sought reconsideration of the portion of the order that awarded an attorney fee of 25 percent of the increased PPD award. It asked if the referee had "thought through" the question of ordering payment of an attorney fee when the increased compensation did not exceed what previously had been paid. The referee issued an order denying reconsideration in which he said:

> **130 Or App 220>** "OAR 438-15-085(2) provides that an attorney fee awardable under Board rules 'to be paid out of increased compensation awarded by a referee * * * shall not be subject to any offset based upon prior overpayment of compensation to the claimant.' It is appropriate to apply this provision to the present circumstances."

The Board adopted the referee's order.

The majority holds that the order "does not provide for an attorney fee *in addition to* compensation to be paid by SAIF." 130 Or App at 218. (Emphasis in original.) SAIF argues and claimant agrees that the effect of the Board's order is that SAIF is required to pay an attorney fee to claimant's attorney in addition to the compensation that it has already paid to claimant. SAIF's reasoning is obscure, but as I understand it, it believes that the Board's order directs it to pay an attorney fee to claimant's attorney and that, under OAR 438-15-085(2), it cannot later obtain an offset for the overpayment that results from payment of the attorney fee.

OAR 438-15-085(2) provides:

> "An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon prior overpayment of compensation to the claimant."

In denying reconsideration, the referee referred to OAR 438-15-085(2) and to *Judy A. Jacobson*, 44 Van Natta 2450 (1992). In that case, the Board increased an award of PPD from 17 percent awarded by the referee to 25 percent and awarded an attorney fee of $500 after the insurer had paid an award of 27 percent pursuant to a determination order. The insurer requested that the Board clarify its order "to point out that no attorney fee is actually payable since there is no additional amount payable to claimant." The Board said that to adopt the insurer's argument would contravene OAR 438-15-085(2). It held that claimant's attorney was entitled to a fee out of the increased benefits and directed the insurer to pay the "out-of-compensation attorney fee awarded by the referee and Board orders."

Apparently, the parties understand the referee's order, when considered in the light of *Jacobson*, to mean that <130 Or App 220/221> an attorney fee equivalent to 25 percent of the increased award is payable to claimant's attorney by SAIF and that the amount paid cannot be part of any future offset against benefits payable to claimant. The net effect of the order as understood by SAIF is that SAIF is required to pay an attorney fee in addition to compensation. If that is the legal effect of the order, then the majority's holding that the order does not provide for an attorney fee in addition to compensation is wrong.

We cannot tell from the face of the order whether the Board intends that SAIF pay an attorney fee in addition to compensation. If we hold that it does not, we decide the case without the benefit of briefs or oral argument on a basis that is different than what has been argued by the parties. Moreover, we will perpetuate review of an ambiguous order. Rather, we should remand to the Board and require it to expressly tell us whether it is directing that SAIF pay an attorney fee in addition to the compensation that it has already paid. If it is not, then SAIF's concern has no basis. If the Board considers the legal effect of its order to be that SAIF is required to pay an attorney fee in addition to compensation, then SAIF can seek review, and we can consider its arguments on their merits.

Cite as 130 Or App 254 (1994) September 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard J. Messmer, Claimant.

RICHARD J. **MESSMER**, Petitioner,
v.
DELUXE CABINET WORKS and AETNA CASUALTY CO., Respondents.
(91-12265; CA A79805)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 18, 1994.

Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson & Atchison.

Jerald P. Keene argued the cause for respondents. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

WARREN, P.J.

Reversed and remanded for reconsideration.

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130 Or App 256> Claimant seeks review of an order of the Workers' Compensation Board that upheld employer's denial of his aggravation claim. We reverse.

In 1987, claimant injured his neck and right shoulder at work. Employer accepted the claim, which had been diagnosed as thoraco-cervical strain and myofascitis. The following month, claimant's physician diagnosed degenerative disc disease in his neck. Employer neither accepted nor denied compensability of that disease, but authorized surgery for it, which was performed in 1988. In 1989, the claim was closed by determination order, which awarded permanent partial disability based in part on the effects of the surgery that had treated the degenerative disc disease. There was no appeal of the determination order.

In 1991, after claimant's pain worsened, his physician requested authorization for surgery for progressive degenerative changes to his cervical spine. Employer denied compensability of that condition, based on a lack of connection between the worsened condition and the accepted thoraco-cervical strain. Claimant appealed, arguing that employer's failure to deny the degenerative condition and its failure to seek review of the determination order has preclusive effect, barring employer from now denying compensability of the worsening of the degenerative condition. Employer argues that the only condition it accepted was the strain to the neck and back, and that its payment of compensation under the determination order for the degenerative disc disease does not constitute acceptance of a claim for the degenerative condition. Therefore, it argues, it can deny the claim for the worsening of the degenerative condition.

The Board adopted the referee's finding that employer accepted a strain injury and that it did not accept the degenerative disc condition. Claimant does not challenge that finding. The Board also concluded that employer was not precluded from denying the compensability of claimant's aggravation claim, because

> "neither the employer's approval of payment for surgery nor its failure to challenge a Determination Order which awarded benefits for the residuals of the surgery constituted **<130 Or App 256/257>** acceptance of the degenerative condition which the surgery was designed to treat."

Claimant argues on review that employer is barred by claim preclusion from denying the compensability of the degenerative condition, which has now worsened and requires treatment. Claimant argues:

> "[I]t is impermissible, given the facts, for [employer] to deny the compensability of claimant's degenerative disc disease or need for additional surgery. When the determination order issued, [employer] knew claimant's condition--and the compensation awarded--included elements of degenerative disease. [Employer] could have--and should have--denied that which it believed to be non-compensable. But [employer] did not. It is stuck with the result because of claim preclusion."

Employer argues that a determination order does not decide issues of causation, and therefore claim preclusion does not prevent it from later denying the compensability of a condition for which an award of compensation was made by the determination order.

In *Drews v. EBI Companies*, 310 Or 134, 795 P2d 531 (1990), the Supreme Court held that claim preclusion applies to workers' compensation decisions. Claim preclusion bars litigation of a claim based on the same factual transaction as was or could have been litigated between the parties in a prior proceeding that has reached a final determination. 310 Or at 142-43; *SAIF v. Hansen*, 126 Or App 662, 870 P2d 247 (1994). A determination order that is not appealed and has become final can give rise to application of the principle of claim preclusion. *Drews v. EBI Companies, supra*, 310 Or at 149; *Hammon Stage Line v. Stinson*, 123 Or App 418, 422, 859 P2d 1180 (1993). There is no argument in this case that the determination order is not final. Therefore, the question is whether employer could have litigated the scope of the accepted claim, *i.e.*, whether the accepted claim encompassed the degenerative condition, in the determination order or in an appeal from that order.

The purpose of the determination order was not to decide disputes about acceptance or denial, but was to make a determination about the extent of claimant's disability resulting from the claim and to award compensation in accordance with that determination. The order did that. **<130 Or App 257/258>** However, as we recognized in *Hammon Stage Line v. Stinson, supra*, the award made by the determination order was based on certain underlying facts. For example, in *Hammon Stage Line*, the award was based on a certain wage rate, which the claimant later argued was incorrectly determined. We held that, as to the award that had become final because it was not appealed, claimant was precluded from challenging the wage rate used to calculate his temporary disability benefits.

In this case, one of the underlying facts on which the compensation award was based was the scope of the compensable claim. The scope of the compensable claim is inseparable from the determination of the extent of disability. Employer could have appealed the determination order and challenged the award if it believed that it was being made in part for a noncompensable condition. It did not do that. Therefore, claim preclusion bars it from later arguing that the condition for which the award was made is not part of the compensable claim.

According to the Board's findings, the determination order included compensation for residuals of surgery for the degenerative condition. That condition had never been accepted by employer. However, employer did not appeal the award, and paid the compensation ordered. Although employer's payment of the compensation, by itself, does not constitute acceptance of a claim for the degenerative condition, ORS 656.262(9), employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precludes employer from contending later that that condition is not part of the compensable claim. The result is not that the degenerative condition has been accepted; it is that employer is barred by claim preclusion from denying that it is part of the compensable claim.

The Board erred in concluding that employer is not required to treat the degenerative condition, which has now worsened, as part of the compensable claim. Therefore, we remand to the Board for reconsideration.

Reversed and remanded for reconsideration.

Cite as 130 Or App 297 (1994) September 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Steven S. Ewen, Claimant.

FOOD SERVICES OF AMERICA, Petitioner,
v.
STEVEN S. **EWEN**, Respondent.
(91-07052; CA A78598)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 18, 1993.
Karen O'Kasey argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt.
Ronald A. Fontana argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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130 Or App 299> Employer seeks review of a Workers' Compensation Board order holding that claimant was entitled to temporary disability benefits. We reverse and remand.

Claimant injured his foot in 1987 while working in employer's warehouse. Employer accepted his claim. When claimant returned to work, he was assigned to a less physically demanding job than his former job. On April 16, 1990, employer informed claimant that he would no longer be able to work at that job and offered another position. The next day, claimant attempted suicide and was hospitalized for depression.

On May 15, 1990, the Department of Insurance and Finance issued a determination order on claimant's foot injury claim. The order declared claimant medically stationary and awarded temporary and permanent partial disability benefits. In the meantime, claimant returned to work, but continued to suffer from foot pain and from psychological difficulties. In June, 1990, claimant designated Dr. Erde as his treating physician. Erde advised claimant to stop work because of his foot pain, but eventually conditionally released claimant to return to work. Claimant was never offered work within Erde's conditions, and never returned to work. On October 5, 1990, claimant's psychologist, Dr. Kohen, released claimant from work because of his "psychological and physical disabilities."

Claimant sought compensation for his depression on the ground that it was caused by the original foot injury.[1] Employer denied the claim. Claimant requested a hearing. The referee set aside

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[1] Claimant also claimed a worsening of the foot injury. The employer's rejection of that claim is not an issue in this case.

employer's denial, concluding that the major contributing cause of claimant's depression was his foot injury. The referee ordered employer to accept claimant's claim. Employer appealed. For a short period of time during the pendency of the appeal, employer made temporary disability payments. However, after receiving an independent medical opinion that claimant's depression was not disabling, employer informed claimant that it would refuse any **<130 Or App 299/300>** requests for additional disability. Claimant requested a hearing on the employer's denial of temporary disability benefits during the appeal. The referee affirmed, but the Board reversed. The Board held that, during the pendency of employer's appeal of the order setting aside employer's denial, employer remained obligated to pay temporary disability benefits until the order appealed from was reversed or the claim was closed under ORS 656.268. Because the order appealed from had not, in fact, been reversed, and because the claim had not been closed under ORS 656.268, the Board concluded that employer was obligated to pay temporary disability benefits beginning with Kohen's October 5, 1990, work release authorization.

Employer argues that the Board erred in two respects. First, it argues that the Board mistakenly required that claimant's claim be closed under ORS 656.268 before employer may terminate the temporary disability benefits. According to employer, the claim already was closed by the May 15, 1990, determination order declaring claimant medically stationary. That determination order, however, closed claimant's foot injury claim. The temporary disability benefits at issue in this case arise out of claimant's claim for his psychological condition. The Board treated that claim as separate from the claim for the foot injury. There was no appeal from the Board's determination that the psychological condition was compensable. That separate claim has not been closed. The Board, therefore, correctly required that the claim be closed under ORS 656.268 before employer may unilaterally terminate payment of temporary disability benefits.

Second, employer argues that the Board erred in requiring payment of temporary disability benefits from the October 5, 1990, work release of Kohen, because Kohen was not claimant's treating physician. Claimant concedes that, at the time of the October 5, 1990, work release, Kohen was not his treating physician. He argues that, nevertheless, the Board correctly awarded temporary disability benefits from that date, because his treating physician, Erde, had previously authorized the work release.

130 Or App 301> ORS 656.245(3)(b)(B) provides:

> "A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation."

By claimant's own admission, Erde was his attending physician when Kohen wrote his October 5, 1990, time loss authorization. Therefore, the Board erred in awarding temporary total disability based on that October 5, 1990, authorization, which could not trigger employer's obligation to pay temporary disability.

Reversed and remanded for reconsideration.

Cite as 130 Or App 322 (1994) September 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rhonda Purdy, Claimant.

WEYERHAEUSER COMPANY, Petitioner,
v.
RHONDA **PURDY**, Respondent.
(90-00610; CA A78380)

Judicial Review from Workers' Compensation Board.
Submitted on record and brief November 23, 1993.
John M. Pitcher filed the brief for petitioner.
Darrell E. Bewley filed a motion for respondent, but did not file a brief.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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130 Or App 324> Employer petitions for review of an order of the Workers' Compensation Board reversing the referee's dismissal of claimant's request for a hearing on a determination order. We affirm.

In 1984, claimant compensably injured her back while working for employer. Her claim was closed in December, 1985. Her claim was reopened when she began receiving treatment for an adjustment and somatization disorder, which was found to be compensably related to her back injury.

In January, 1989, claimant experienced a temporary exacerbation of her back condition. She was examined on July 1, 1989, by Western Medical Consultants, which reported that her back had returned to medically stationary status, but said nothing about her psychological condition. The Department of Insurance and Finance (DIF)[1] reclosed the claim by a determination order issued on August 23, 1989. DIF found claimant to be medically stationary as of July 1, 1989. At the time the determination order issued, the law provided that claimant could request a hearing on a determination order without first seeking reconsideration of that order. ORS 656.268(6) (*since amended by* Or Laws 1990 (Special Session), ch 2, 16(5)). On January 9, 1990, she did that.

In the meantime, claimant had enrolled in an authorized training program. While she was enrolled in the training, the hearing on the August, 1989, determination order was deferred. During the training, claimant received psychological treatment from a physician, who declared the psychological condition medically stationary in August, 1990. On September 12, 1990, DIF reclosed her claim by a determination order, reaffirming that claimant was medically stationary on July 1, 1989.

By the time of the September, 1990, determination order, the legislature had amended the workers' compensation statutes. Among those amendments is a provision that **<130 Or App 324/325>** now requires a claimant to seek reconsideration of a determination order before requesting a hearing on that order. ORS 656.268(5). That new provision, however, applies only to "claims which become medically stationary after July 1, 1990." Or Laws 1990 (Special Session), ch 2, 54(3). Because both the August, 1989, and the September, 1990, determination orders concluded that claimant became medically stationary before July 1, 1990, claimant did not seek reconsideration, and instead requested a hearing.

The referee found that the determination orders were incorrect, and that claimant's claim had been prematurely closed. According to the referee, claimant did not become medically stationary until August 9, 1990. However, the referee concluded that, because claimant became medically stationary after July 1, 1990, the amendments to the workers' compensation statutes applied, which require her to seek reconsideration from DIF before requesting a hearing before the referee. Because the time for seeking reconsideration had since expired, the referee concluded that the Hearings Division lacked jurisdiction to proceed further, and he dismissed the request for a hearing.

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[1] The department has since been renamed the Department of Consumer and Business Services. ORS 656.005(9).

The Board reversed. Although it agreed with the referee's finding that claimant became medically stationary after July 1, 1990, it concluded that the new law did not apply and that claimant did not have to seek reconsideration of the September, 1990, determination order. According to the Board, when the statute refers to "claims which become medically stationary after July 1, 1990," it

> "refers to claims initially determined to be medically stationary after that date upon closure, so that the application of the 1990 amendments * * * is controlled by the medically stationary date contained in the Determination Order or Notice of Closure."

We express no opinion on the Board's construction of "claims which become medically stationary after July 1, 1990," because we conclude that that language does not apply to this case. The Board and employer failed to appreciate the significance of the fact that claimant enrolled in an authorized training program. That event triggers an entirely separate review process from what is described in ORS 656.268(5), which was unaffected by the 1990 amendments **<130 Or App 325/326>** to the workers' compensation statutes. Whether claimant became medically stationary before or after July 1, 1990, therefore, is irrelevant.

ORS 656.268(8) and (9) provide:

> "(8) If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, [DIF] shall reconsider the claim pursuant to this section unless the worker's condition is not medically stationary. If the worker has returned to work, the insurer or self-insured employer may reevaluate and close the claim without the issuance of a determination order by [DIF].
>
> "(9) [DIF] shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination within 180 days after copies of the determination are mailed."

DIF reconsidered her claim at that time under ORS 656.268(8), and closed that claim by its September, 1990, determination order. Under ORS 656.268(9), claimant may request a hearing on that order. Claimant did that. Her claim, therefore, was properly before the Hearings Division, and the Board not err in holding that it had jurisdiction to review the referee's order.

Employer does not otherwise challenge the Board's order.

Affirmed.

Cite as 130 Or App 346 (1994) September 28, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joyce A. Christensen, Claimant.

SAIF CORPORATION and SAMS FOOD STORE, Petitioners,
v.
JOYCE A. **CHRISTENSEN**, Respondent.
(Agency No. 92-15365; CA A82091)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 24, 1994.
James W. Moller, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Edward Harri argued the cause for respondent. On the brief were Francesconi & Busch, PC, and Floyd H. Shebley.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Reversed.

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130 Or App 348> SAIF seeks review of an order of the Workers' Compensation Board holding that its procedural obligation to begin paying benefits for claimant's temporary total disability began November 11, 1991. The Board's determination is based on its conclusion that an insurer has an affirmative obligation, in the processing of an aggravation claim, to seek medical verification of a claimant's inability to work. We conclude that the Board erred in holding that SAIF had a procedural obligation to begin paying benefits and reverse.

Claimant compensably injured her left elbow and forearm in 1985 while working for employer. The claim was closed in 1988 with an award of permanent partial disability. In 1990, claimant's attending physician, Dr. Long, referred her to Dr. Layman, a surgeon, for consultation. Layman diagnosed cubital tunnel syndrome and radial tunnel syndrome of the left arm, and recommended surgery. He became claimant's attending physician in October, 1990.

In February, 1991, SAIF denied an aggravation claim for the conditions diagnosed by Layman. The claim was ordered accepted by a referee on October 30, 1991. SAIF did not contest that order.

In the meantime, claimant had worked for Burger King from 1987 through early 1991, and for a ceramic tile manufacturer until March, 1991, when she was laid off. She has not worked since that time.

On November 11, 1991, Layman again requested authorization from SAIF to perform surgery. SAIF denied the request. A referee ordered that SAIF pay for the surgery and also assessed an attorney fee, pursuant to ORS 656.382(1), for SAIF's failure to comply with the first referee's order. SAIF did not appeal the order.

On February 12, 1992, in response to interrogatories by claimant's counsel, Long, who was not then claimant's attending physician, expressed the view that claimant was unable to work due to her worsened condition and that she should be authorized time loss until after the surgery.

In August and October, 1992, Layman again requested authorization for surgery. In November, 1992, **<130 Or App 348/349>** claimant's counsel requested that SAIF process the claim for aggravation and that it begin paying time loss.

In February, 1993, SAIF closed the claim without an award for time loss or permanent disability. It is not clear from this record whether claimant has had her surgery, but it is assumed that she has, in the light of SAIF's closure of the claim. The only issue on review concerns when, if ever, SAIF became obligated, from a procedural standpoint, to begin paying benefits for temporary disability. This case is not about whether claimant is substantively entitled to benefits for temporary disability. SAIF contends on review that it never had an obligation to begin paying benefits, because it never received notice from claimant's attending physician that claimant was unable to work.

In the context of an initial claim, ORS 656.262(4) provides:

> "(a) The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. * * *
>
> "(b) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

ORS 656.273(6) provides that a claim for aggravation

> "shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, *except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work* resulting from a compensable worsening * * *." (Emphasis supplied.)

The statutes indicate that the processing of an aggravation claim should be identical to the processing of an initial claim, with one exception. In an initial claim, the first payment of compensation is due no later than the 14th day after the insurer has notice or knowledge of the claim. ORS 656.262 also provides that if, in an initial claim, the insurer requests **<130 Or App 349/350>** and does not receive from the claimant's attending physician verification of the inability to work, no time loss is due. In an aggravation claim, the first installment of compensation is due no later than the 14th day after the subject employer has notice or knowledge of a medically verified inability to work. This case turns on the significance of the differences in the two statutes with regard to the obligation to begin paying benefits for time loss.

The first issue is whether, for the purpose of triggering the employer's procedural obligation to begin paying benefits on an aggravation claim, "notice or knowledge of a medically verified inability to work" must come from the claimant's attending physician, or whether the claimant's inability to work may be "medically verified" by another source. ORS 656.273(6) does not provide expressly that medical verification must come from the attending physician, although the statute does require that the claim be processed under ORS 656.262, which, as we have noted, expressly requires that, *when sought by the employer*, medical verification must come from the claimant's attending physician. If the answer to our question depended exclusively on an interpretation of ORS 656.273(6) and ORS 656.262, it is possible that we would conclude that the employer's notice of a medically verified inability to work need not come from the claimant's attending physician. However, in 1990, the legislature enacted ORS 656.245(3)(b)(B), which provides:

> "A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation."

By that statute, the legislature has expressly provided that authorization for time loss can come only from the claimant's attending physician. We conclude that ORS 656.245(3)(b)(B) applies to any claim for time loss, be it an initial claim or an aggravation claim; and that it applies not only with regard to substantive entitlement to benefits, but in this procedural context as well. Medical verification of an inability to work so as to trigger the insurer's obligation to begin paying benefits for time loss on an aggravation claim must come from the claimant's attending physician. Accordingly, we hold that Long could not have provided the medical verification of **<130 Or App 350/351>** claimant's inability to work, because he was not claimant's attending physician.

The Board did not regard the absence of express medical verification from claimant's attending physician as fatal to claimant's entitlement to benefits for time loss. Apparently drawing by analogy on the terms of ORS 656.262(4)(b), the Board held that, if SAIF doubted that claimant was disabled, SAIF had an obligation in its processing of the claim to seek medical verification of her inability to work. The Board found that, if SAIF had sought verification from Layman, who was claimant's attending physician at the time of the November 11, 1991, request for authorization for surgery, SAIF would have learned that claimant was disabled. Accordingly, the Board held that there was "sufficient medical verification" from an attending physician. The Board found that SAIF's duty to begin paying benefits began as of November 11, 1991, when, the Board concluded, SAIF should have sought verification from Layman.

The Board further found that SAIF had unreasonably processed the claim and assessed a penalty pursuant to ORS 656.262(10).

We agree with the Board that, read in their context, the statutory provisions for the processing aggravation claims can be reasonably interpreted to place on the insurer a duty (analogous to that applicable with respect to an initial claim) to seek medical verification of an inability to work. Nonetheless, to hold that the obligation to begin paying time loss benefits on an aggravation claim can be triggered in the absence of medical verification of an inability to work would be contrary to the provisions of ORS 656.273(6). Although the Board found that SAIF acted unreasonably in failing to seek medical verification of claimant's inability to work on November 11, 1991, it does not follow that SAIF had a duty to begin paying benefits, because there was no medical verification of an inability to work. Additionally, because there were no benefits due, the Board erred in assessing a penalty.

Reversed.

Cite as 130 Or App 391 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John G. Williamson, Claimant.

SAIF CORPORATION and CLACKAMAS COUNTY SCHOOL DISTRICT #108, Petitioners,
v.
JOHN G. **WILLIAMSON**, Respondent.
(WCB No. 91-12264; CA A80654)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 7, 1994.
James W. Moller, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Helen T. Dziuba argued the cause for respondent. On the brief were Kimberley Chaput and Pozzi, Wilson and Atchison.
Before Deits, Presiding Judge, and Richardson, Chief Judge, and Riggs, Judge.
DEITS, P.J.
Affirmed.

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130 Or App 393> In this workers' compensation case, employer seeks reversal of an order of the Board that increased claimant's scheduled permanent disability award for his right leg to 18 percent. We affirm.

In 1968, claimant had a non-work-related accident, which resulted in a below-the-knee amputation of his right leg. In 1977, he went to work as a school custodian. He was able to satisfactorily perform the responsibilities of that job until 1986, when he was transferred to a position that required more walking and allowed him less time off his feet. He then developed a swelling and weeping out of his right leg stump. In 1987, he left his job as a custodian.

Claimant then filed a workers' compensation claim for cellulitis of the right stump, which was accepted by his employer. In April, 1991, his claim was closed with an award of five percent scheduled permanent disability of the right foot. Claimant requested a hearing on the award. After the hearing, the referee increased the award of scheduled permanent disability to 18 percent for loss of use of the right leg. The referee's order included a value based on OAR 436-35-200(4),[1] for claimant's permanent inability to walk or stand for greater than two hours in an eight-hour period. The Board affirmed the increased award, explaining:

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[1] OAR 436-35-200(4) provides, in part:

"When a preponderance of objective medical evidence indicates an accepted compensable injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an eight-hour period, the award shall be 15 percent of the foot. This value is combined with all other scheduled impairment findings in the foot."

> "An award of 15 percent impairment pursuant to OAR 436-35-200(4) requires objective medical evidence of inability to walk or stand for greater than two hours. Here, although Dr. McKillop stated that he could not provide objective findings for claimant's inability to walk or stand for greater than two hours, he nevertheless concluded that claimant was unable to walk or stand for more than two hours. Similarly, Dr. Thomas thought claimant's ambulatory potential was very limited, yet his physical examination of the stump appeared negative: The stump looks good, without blisters or callouses, is non-tender, has full range of **<130 Or App 393/394>** motion, no pain and the prosthesis is wearing well. The record shows that each physician's conclusion regarding claimant's inability to walk or stand for more than two hours was based on his evaluation of the worker's description of his limitations, which is sufficient to establish 'objective findings.' *Georgia-Pacific Corp. v. Ferrer,* 114 Or App 471[, 835 P2d 949] (1992)." (Exhibit references omitted.)

Employer argues that the Board erred in increasing the award of scheduled permanent disability. It contends that the Board improperly relied on our decision in *Georgia-Pacific Corp. v. Ferrer, supra,* for the proposition that a physician's evaluation of a worker's description of his limitations may alone constitute "objective findings," as required by ORS 656.726(3)(f)(B).[2] Employer contends that there is a complete absence of "objective findings" here and that, therefore, there was no basis for the Board to increase claimant's award.

The issue in *Ferrer* was very similar to the one presented here. We characterized the question in that case as whether a physician's evaluation of a worker's subjective complaints constitutes "objective medical findings." However, employer is correct that, unlike in this case, in *Ferrer,* there was more than a physician's evaluation of a claimant's subjective complaints. In addition to the physician's evaluation of the subjective complaints, on examination, the physician observed some physical evidence of the condition; namely, muscle spasms and tenderness. In reaching the conclusion in *Ferrer* that there was objective medical evidence to support a determination of compensability, we indicated that we relied on *both* the physician's evaluation of the subjective complaints and the physician's observation of physical symptoms:

> **130 Or App 395>** "[O]n the basis of their objective evaluations of claimant's complaints of pain in specific areas of his back and his muscular responses during physical examinations, all three doctors in this case concluded that claimant suffers from a cervical dorsal strain." 114 Or App at 475.

Similarly, our holdings in *SAIF v. Cruz,* 120 Or App 65, 67, 852 P2d 247 (1993), and *Hewlett-Packard Co. v. Holden,* 115 Or App 390, 838 P2d 643 (1992), on which employer relies, also involve circumstances where there was some corroborating physical evidence of the claimant's subjective complaints that the physician considered in evaluating the claimant's condition.

In *Stanley Smith Security v. Pace,* 118 Or App 602, 848 P2d 1218, *rev den* 317 Or 272 (1993), however, in the context of an aggravation claim, we held that a chiropractor's evaluation of a claimant's subjective complaints constituted objective findings sufficient to support a determination that the claimant's condition had worsened and was compensable. In that case, as in *Georgia-Pacific Corp. v. Ferrer, supra,* we quoted with approval the Board's understanding of the legislative intent regarding the use of the term "objective findings":

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[2] ORS 656.726(3) provides, in part:

> "The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:
>
> "* * * * *
>
> "(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:
>
> "* * * * *
>
> "(B) Impairment is established by a preponderance of medical evidence based upon objective findings."

> "'[T]he legislature did not intend to exclude those findings based on an injured worker's subjective complaints. Rather, we believe that the intent was to require a determination by a physician, based on examination of the injured worker, that an injured worker has a disability or need for medical services. *Such a finding* may be based on a physically verifiable impairment, but, as stated by the committee members, *may also be based on the physician's evaluation of the worker's description of the pain that she is experiencing.*" 118 Or App at 605. (Citation omitted; emphasis in original.)

We continue to believe that that understanding of the legislative intent is correct and that a physician's evaluation of a worker's subjective complaints may itself constitute objective findings under ORS 656.726(3)(f)(B).

Employer argues that our earlier decisions concerning what constitutes "objective findings" are distinguishable because they all concerned the meaning of the term in the context of compensability claims under ORS 656.005(7), rather than, as here, in the context of a dispute regarding the **<130 Or App 395/396>** extent of impairment. ORS 656.726(3)(f)(B). We do not believe that this distinction makes a difference. The term "objective findings" is defined in ORS 656.005(19):

> "'Objective findings' in support of medical evidence include, *but are not limited to,* range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." (Emphasis supplied.)

ORS 656.003 provides that, "[e]xcept where the context otherwise requires, the definitions in this chapter govern its construction." There is no indication either in the text or context of the statutes or in the legislative history that the meaning of" objective findings" as used in ORS chapter 656 should vary by context.

Here, the physicians evaluated claimant's subjective complaints. Claimant's treating physician, McKillop, concluded:

> "It would be my opinion that this man is severely limited in his ability to stand and walk. He should have a sitting job. Basically, that is what he is doing in running his toy shop. He sits most of the time and moves from one chair to another as he talks to customers."

McKillop also indicated that claimant was limited by an inability to walk or stand for greater than two hours in an eight-hour period. Dr. Thompson, who performed an independent medical examination, concluded:

> "[Claimant] has never been able to return to his previous functional level where he was working as a custodian. It is felt that he is not able to return to work as a custodian even if it was modified. At the present time, his ambulatory potential is very limited and he needs a full-time sedentary job."

There is no physical evidence corroborating the physicians' evaluations. Nonetheless, for the reasons discussed above, we conclude that the physicians' evaluations of claimant's subjective complaints are objective findings sufficient to support the Board's determination that claimant's award of scheduled permanent disability should be increased to 18 percent.

Affirmed.

Cite as 130 Or App 397 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert L. Dietz, Claimant.

ROBERT L. **DIETZ**, Petitioner,
v.
RAMUDA and SAIF CORPORATION, Respondents.
(92-09712; CA A81010)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 23, 1994.
Floyd H. Shebley argued the cause and filed the brief 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.
No appearance for respondent Ramuda.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
DEITS, P.J.
Affirmed.

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130 Or App 399> Claimant seeks review of an order of the Workers' Compensation Board upholding SAIF's denial of his claim for compensation for a heart attack that occurred after he was exposed to smoke while on the job. We affirm.

Claimant, who was 63 years old at the time of hearing, worked at employer's meat processing plant for 18 years. In January, 1992, during the course of his work, he breathed smoke from an electrical fire for approximately seven minutes. Within a few minutes of the exposure to the smoke, he began to cough, was nauseated and felt chest pain. He was taken to the hospital where it was determined that he was having an "acute, inferior-wall, myocardial infarction." Claimant was treated and was off work for about four months as a result of the condition. Before the January, 1992, incident, claimant had been diagnosed with coronary artery disease that significantly obstructed his coronary arteries. However, that condition had been asymptomatic.

Claimant sought workers' compensation benefits for the heart attack as well as the resulting disability and need for treatment. SAIF, on behalf of the noncomplying employer, denied the claim. Claimant requested a hearing, which was held in October, 1992. The referee upheld SAIF's denial, holding that the claim was for an occupational disease and that claimant had failed to prove that his work activities were the major contributing cause of the heart attack. The Board also upheld the denial. It held, however, that it was not necessary to decide if this was an occupational disease claim or an injury claim, because claimant had a preexisting coronary artery disease. Accordingly, the Board concluded that even if the claim is an injury, it must be considered under ORS 656.005(7)(a)(B) and that, under that statute, the condition is compensable only if the work activity is the major contributing cause of the claimant's disability or need for treatment. The Board concluded that claimant had failed to prove that the smoke incident at work was the major contributing cause of his heart attack and consequently upheld SAIF's denial of the claim.

Claimant argues first that the Board applied the wrong legal standard in analyzing this claim. He contends **<130 Or App 399/400>** that the Board should have applied a material contributing cause standard rather than a major contributing cause standard because his claim is for an injury, not an occupational disease. In this case, however, the major contributing cause standard is applicable regardless of whether this is a claim for an injury or a disease. A major contributing cause standard applies if this is a disease claim. Further, even assuming that claimant is correct that this is an injury claim,[1] it is undisputed that claimant had a preexisting condition. Under ORS 656.005(7)(a)(B), which applies when a compensable injury combines with a preexisting condition, the inquiry is whether the work incident was the major contributing cause of claimant's condition. *Tektronix, Inc. v. Nazari*, 117 Or App 409, 412, 844 P2d 258 (1992), *mod* 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993). The Board did not err in applying the major contributing cause standard.

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[1] Under *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994), it would appear that this claim constitutes an injury.

Claimant next argues that even if the major contributing cause standard is applicable here, the Board erred as a matter of law in concluding that his work activities were not the major contributing cause of his heart attack. He argues:

> "Five doctors have addressed the issue of medical causation. All of them agree that claimant's work activities on January 13, 1992 caused or precipitated his myocardial infarction. Thus, Dr. Dantas says the 'incident was probably precipitated by his smoke inhalation'; Dr. DeMots states that claimant probably would not have had a heart attack on January 13 'if he had not been exposed to the smoke at work'; Dr. Browning reports claimant's heart attack was 'directly precipitated on 1-13-92 by the physiologic stresses of smoke inhalation during which time the patient was transiently hypoxic'; Dr. Grover's 'strong opinion that [claimant's] heart attack was precipitated by smoke inhalation on 1/13/92' and this attack would not have occurred 'at that time without this smoke inhalation'; and Dr. Toren feels 'it is likely that his smoke inhalation contributed in a significant way to his having had the infarction when he did." (Exhibit references omitted.)

Claimant asserts that, based on that evidence, as a matter of law, the only reasonable conclusion that the Board could reach was that claimant's work activities were the **<130 Or App 400/401>** major contributing cause of his heart attack. Claimant's argument, however, depends on the assumption that it necessarily follows from the doctors' statements that the smoke incident "precipitated" his heart attack and, therefore, that the smoke incident was the major contributing cause of the heart attack. In essence, it is claimant's position that a work event that is the immediate cause of a disease or injury is always also the major cause. Following that reasoning, claimant asserts that because all of the doctors either said that the smoke incident caused or precipitated the heart attack, as a matter of law, the work incident was the major contributing cause of his heart attack. SAIF, on the other hand, contends that ORS 656.005(7)(a)(B) requires "a comparison of the relative contribution of the preexisting disease or condition and the work-related incident."

In determining the meaning of ORS 656.005(7)(a)(B), we look first to the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). Subsection (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."

The language of the statute supports SAIF's reading of it. The statute requires an assessment of the "major contributing cause." Generally, it has been held that determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the *primary* cause. *See McGarrah v. SAIF*, 296 Or 145, 675 P2d 159 (1983); *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983); *Liberty Northwest Ins. Corp. v. Spurgeon*, 109 Or App 566, 820 P2d 851 (1991), *rev den* 313 Or 210 (1992). Under claimant's reading of the statute, an assessment of the relative contribution of different causes would not occur because the immediate cause would always be the major cause. We conclude that, although work activities that precipitate a claimant's injury or disease may be the major contributing cause, that is not necessarily always true. Under ORS 656.005(7)(a)(B), the **<130 Or App 401/402>** relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances. Accordingly, the Board did not err as a matter of law in its application of the major contributing cause test under ORS 656.005(7)(a)(B).

Finally, claimant argues that substantial evidence does not support the Board's finding that his preexisting condition was the major contributing cause of his heart attack and the resultant disability and need for treatment. We disagree. Although there is conflicting evidence in the record, the opinions of two doctors, DeMots and Toren, support the Board's conclusion that claimant's preexisting condition was the major contributing cause of the heart attack. The Board did not err in upholding SAIF's denial.

Affirmed.

Cite as 130 Or App 414 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of DeMar L. Batchelor, Deceased, Claimant.

SAIF CORPORATION and BRISBEE & STOCKTON, Petitioners,
v.
JUDITH G. **BATCHELOR**, Beneficiary of DeMar L. Batchelor, Deceased, Respondent.
(WCB No. 92-00598; CA A80656)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 14, 1994.
David L. Runner, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Kevin Keaney argued the cause for respondent. On the brief were Jodie A. Bushman and Pozzi Wilson & Atchison.
Before Deits, Presiding Judge, and Richardson, Chief Judge, and Haselton, Judge.
DEITS, P.J.
Affirmed.

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130 Or App 416> Employer seeks review of an order of the Workers' Compensation Board awarding survivor's benefits to the widow of a worker who died as a result of a heart attack allegedly caused by job stress. We affirm.

Decedent was a lawyer who practiced in a small firm in Hillsboro. Over the years, his relationship with one of the persons with whom he practiced deteriorated significantly. Eventually, the situation became so hostile that it was necessary to attempt to negotiate an end to the business relationship. The discussions that occurred concerning how to resolve the dispute quickly became antagonistic. During the same time period, a long-time client filed two malpractice lawsuits against decedent. Both of those situations were extremely upsetting to decedent. During that time, decedent was also managing a busy practice that required him to work long hours. Those close to him, who observed him during that time, said that the effect of the stress of these events was very evident and was substantial. A colleague who was handling the malpractice case for decedent and who had known him for a long time stated that, during a meeting regarding the lawsuits, decedent, who generally was calm, was terribly upset and appeared flushed and agitated.

Decedent was found dead at his home on June 18, 1991. He was not under medical care at the time of his death, and there is no evidence that, before his death, he had been aware of any health problems that required medical attention. An autopsy revealed that he had coronary artery disease and myocarditis. The two cardiologists who examined decedent's records concluded that he died of ventricular fibrillation, which is an abnormal loss of heart rhythm that causes the heart to be ineffective in moving blood through the body. Both doctors agreed that stress contributed to decedent's death, but they disagreed on the magnitude of the contribution.

One of the cardiologists, Dr. Toren, stated that, in his opinion, decedent's underlying cardiac problems could have predisposed him to sudden death by ventricular fibrillation. However, he indicated that it was uncommon for coronary artery disease or myocarditis to result in sudden death absent **<130 Or App 416/417>** a trigger, such as extraordinary physical exertion or exceptional emotional stress. Toren concluded that the emotional stress that decedent was experiencing lowered his threshold for fibrillation and "played a major contributing role" in the fibrillation occurring when it did. He stated that claimant would not have died at the time that he did, had it not been for the stress that he was undergoing.

Dr. DeMots, the other cardiologist who reviewed decedent's records, did not completely agree with Toren. DeMots identified three potential factors that he believed could have contributed to decedent's ventricular fibrillation: coronary artery disease, myocarditis and stress. It was his opinion that the myocarditis was the major cause of the fibrillation, that the stress was a contributing, but minor, factor and that the coronary artery disease did not contribute at all.

Decedent's widow, claimant, filed a claim for death benefits. Employer denied the claim, and claimant requested a hearing on the denial. The referee concluded that decedent's work activities were the major contributing cause of his death and set aside the denial. The Board adopted the hearings officer's findings. It concluded that, under *SAIF v. Hukari*, 113 Or App 475, 833 P2d 1307, *rev den* 314 Or 391 (1992), the case must be analyzed as an occupational disease claim because it involved a claim in which the condition was allegedly caused by on-the-job stress, and that, accordingly, in order to be compensable, decedent must have suffered from a mental disorder. ORS 656.802(3). It then found that decedent did suffer from a mental disorder and held that the claim was compensable, because decedent's work environment "constituted the major contributing cause of his psychological condition, which, in turn, led to his fatal fibrillation condition and, ultimately, his death." Employer seeks review of the Board's order.

Employer first argues that the Board erred in concluding that decedent suffered from a mental disorder. Employer contends that mental stress is not a "diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community" within the meaning of ORS 656.802(3)(c). It is unnecessary, however, to address that question. After this case was argued before this court, **<130 Or App 417/418>** the Supreme Court issued its decision in *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994). The court held in *Mathel* that a heart attack, including one precipitated by job stress, is an "injury" claim. Accordingly, this case should not be analyzed as an occupational disease claim, and a determination as to whether or not stress is a "mental disorder" for purposes of the occupational disease statute is now irrelevant.

We recognize that the Board did analyze this claim as a disease claim, rather than as an injury claim as *Mathel* now requires. However, because the Board found that decedent's work activities were the major contributing cause of his death, it necessarily follows that the claim would be compensable if it is analyzed under ORS 656.007(7)(a)(B) as involving a preexisting condition or if it is analyzed as an injury where the material contributing cause standard would apply. It would serve no purpose to remand the case for the Board to reconsider its decision.

Employer also argues that the Board's conclusion that decedent's work related stress was the major contributing cause of his death by ventricular fibrillation is not supported by substantial evidence. We disagree. The Board's conclusion was supported by substantial evidence, namely, the testimony of Dr. Toren. Although, as discussed above, there was conflicting medical evidence, the Board explained that it was accepting Toren's opinion because, in its view, his opinion was more complete and well reasoned than DeMots's opinion. Toren's opinion constituted substantial evidence to support the Board's conclusion. The Board did not err in concluding that the claim is compensable.

Affirmed.

Cite as 130 Or App 429 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael L. Whitney, Claimant.

SAIF CORPORATION and JERRY HAMMITT LOGGING, Petitioners,
v.
MICHAEL L. **WHITNEY**, ROSE LOGGING, INC. and EBI COMPANIES, Respondents.
(WCB 92-00485; WCB 92-00484; CA A79277)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 23, 1994.
David L. Runner, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Edward J. Harri argued the cause for respondent Michael L. Whitney. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll.
Patric J. Doherty and VavRosky, MacColl, Olson, Doherty & Miller waived appearance for respondents Rose Logging, Inc. and EBI Companies.
Before Deits, Presiding Judge, and Richardson, Chief Judge, and Riggs, Judge.
RIGGS, J.
Affirmed.

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130 Or App 431> SAIF seeks review of an order of the Workers' Compensation Board imposing penalties against SAIF. SAIF argues that by awarding the maximum penalty against two different insurers in the same case, the Board exceeded the limitation on penalties contained in ORS 656.262(10)(a). We affirm.

Claimant suffered a compensable back injury in 1989 while working for EBI's insured. In 1991, claimant suffered a flare-up of back pain while working for SAIF's insured. He filed a new injury claim with SAIF and an aggravation claim with EBI. Both insurers denied the compensability and responsibility for the claim; therefore, no order issued pursuant to ORS 656.307.[1] Claimant requested a hearing on both denials.

The Board ultimately concluded that EBI was responsible and set aside EBI's denial. In addition, the Board concluded that both insurers had unreasonably denied compensability and assessed penalties against both insurers of 25 percent of the amount due, pursuant to ORS 656.262(10)(a).

SAIF assigns error to the assessment of penalties against it. ORS 656.262(10)(a) controls our decision. It provides:

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

SAIF argues that, by imposing 25 percent penalties against *both* insurers, the Board exceeded the 25 percent limitation in ORS 656.262(10)(a). The question is whether the 25 percent **<130 Or App 431/432>** is a limit on the total amount of penalties, or only the penalty assessed against a single insurer.

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[1] ORS 656.307 provides, in part:

"(1) Where there is an issue regarding:

"* * * * *

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries;

"* * * * *

"the director shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable."

This case turns on the legislature's intent in enacting ORS 656.262(10)(a). We begin by looking to the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The statute is directed at the insurer's conduct, not at its effect on a particular claimant. If the insurer's conduct is unreasonable, then the insurer "shall" be liable for an additional amount up to 25 percent. If two insurers, or for that matter, four insurers, act unreasonably, we see no reason why they should not each be liable for a penalty of up to 25 percent. The language of the statute does not indicate that the legislature intended to limit the total amount of penalties that could be awarded, only the amount that could be awarded against any one insurer. Accordingly, we conclude that the 25 percent limitation in ORS 656.262(10)(a) applies only to the award of penalties against a particular insurer.

SAIF v. Moyer, 63 Or App 498, 664 P2d 1140, *rev den* 295 Or 541 (1983), supports that conclusion. In that case, SAIF unreasonably denied the compensability of a claim. We held that, even though SAIF was not responsible for the claim, it was still liable for penalties because of its unreasonable denial. SAIF's liability rested on the reasonableness of its own action, not on its responsibility to a particular claimant. The purpose of the penalties under ORS 656.262(10) is to encourage responsible claims processing. It is not appropriate that an insurer escape liability for penalties, even though it acted unreasonably, solely because another insurer is ultimately responsible for the claim.

Affirmed.

Cite as 130 Or App 454 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Theresa J. Lester, Deceased, Claimant.

JOHN C. **URNESS**, Personal Representative of the Estate of Theresa J. Lester, Deceased, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and OREGON ASPHALT PAVING,
Respondents.
(TP-90061; CA A79870)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 14, 1994.
W. Eugene Hallman argued the cause for petitioner. With him on the brief were Gene B. Mechanic and Goldberg & Mechanic.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Reversed and remanded for reconsideration.

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130 Or App 456> Petitioner seeks review of the Workers' Compensation Board's distribution of settlement proceeds. ORS 656.298. He contends that the Board failed to exercise its discretion in determining a "just and proper" distribution of settlement proceeds in accordance with ORS 656.593(3). We reverse and remand.

The facts of this case are set forth in *Liberty Northwest Ins. Corp. v. Golden*, 116 Or App 64, 840 P2d 1362 (1992), *rev den* 315 Or 442 (1993), and we summarize those facts necessary for our review. Petitioner is the personal representative of the estate of Lester, who died in a job-related accident. Liberty Northwest Insurance Corporation (Liberty) is employer's workers' compensation insurance carrier. It accepted a workers' compensation claim and paid benefits to decedent's husband and children. Petitioner brought a wrongful death action against a third party for the benefit of the decedent's husband and children. The third party settled the action for $300,000, and Liberty did not object to the amount of the settlement. Petitioner petitioned the probate court for an order apportioning the settlement to the beneficiaries under ORS 30.040. With the husband's concurrence, the probate court allocated one-half of the settlement to each child and nothing to the husband.

Petitioner then petitioned the Board to resolve a dispute as to the amount that Liberty could recover from the settlement under ORS 656.593, which provides, in part:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. * * * *The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds* as set forth in this section and the total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

130 Or App 457> "(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. * * *

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

"(2) The amount retained by the worker or the beneficiaries of the worker shall be in addition to the compensation or other benefits to which such worker or beneficiaries are entitled under this chapter.

"(3) *A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds which may be just and proper* and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board." (Emphasis supplied.)

The Board held that the claim costs attributable to an individual beneficiary should be payable only from the amount of the settlement allocated to that beneficiary by the probate court. The Board concluded that, because none of the proceeds were allocated to the husband, none of the claim costs related to him were recoverable from the settlement.

Liberty sought review, and we remanded the case to the Board, explaining:

"The structure of ORS 656.593 is that the paying agency's lien attaches to the gross proceeds of the settlement after the costs of obtaining it are subtracted, ORS 656.593(1)(a), and one-third of the balance is distributed to the estate for the beneficiaries. ORS 656.593(1)(b). After those deductions, the paying agency is to receive what is just and proper toward payment of its lien and the remainder is distributed to the beneficiaries. The probate court may determine, under ORS 30.030, the allocation of the amounts distributed pursuant to ORS 656.593. The action of the probate court cannot determine the amount available for discharge of the paying **<130 Or App 457/458>** agency's lien by allocating settlement proceeds to the beneficiaries designated under the Workers' Compensation Law." *Liberty Northwest Corporation v. Golden, supra,* 116 Or App at 67-68.

Thus, the problem with the Board's original order was not that it was an "[un]just and [im]proper" distribution, but that the Board relied on the probate court's allocation to determine the agency's share of the proceeds. The probate court's order distributed only the amount of the proceeds left after satisfaction of the agency's share; it could not determine the amount of the lien. We concluded that the approach taken by the Board "put the cart before the horse" and held:

"The Board has some discretion to determine what is just and proper for the paying agency to receive, but that discretion must be exercised in the proper legal framework. Because the Board used the wrong legal standard, we remand for reconsideration." 116 Or App at 69.

Now, on remand, the Board has put a horse before the cart but has used the wrong horse. It held that, "consistent with our longstanding policy of avoiding distributions on an ad hoc basis," it would distribute the proceeds in accordance with ORS 656.593(1). However, distributions on an "ad hoc" basis are exactly what ORS 656.593(3) contemplates in the distribution of settlement proceeds in circumstances such as these. Each case should be judged on its own merits when determining a "just and proper" distribution. Although either of the Board's decisions may, in fact, have been a "just and proper" resolution, the method the Board used in reaching those decisions was improper. We remand for the Board to exercise its discretion to arrive at a "just and proper" distribution of settlement proceeds.

Reversed and remanded for reconsideration.

Cite as 130 Or App 507 (1994) October 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Deanna F. Marshall, Claimant.

SAIF CORPORATION and DEE'S BEAUTY NOOK, Petitioners,
v.
DEANNA F. **MARSHALL**, Respondent.
(92-09708; CA A81381)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 18, 1994.
James W. Moller, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Kevin Keaney argued the cause for respondent. With him on the brief was Pozzi Wilson & Atchison.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
HASELTON, J.
Reversed and remanded for reconsideration.

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130 Or App 509> SAIF seeks review of an order of the Workers' Compensation Board setting aside its denial of a claim for compensation. In particular, SAIF contends that the Board erroneously construed the "corroborative evidence" requirement of ORS 656.128(3). We reverse and remand.

Claimant, a hairdresser, is the sole proprietor of a beauty salon. In April, 1992, claimant filed a claim for a right shoulder and arm condition, which she alleged was caused by her work activities. SAIF denied that claim, asserting that, under ORS 656.128(3), claimant, as a sole proprietor claiming compensation, was required to present evidence corroborating her own statements that her condition was compensably work-related, and that claimant had failed to present such evidence.[1] The referee rejected SAIF's argument and set aside the compensability denial, and the Board affirmed. Both the referee and the Board concluded that the "corroborative evidence" requirement of ORS 656.128(3) pertains to proof of a sole proprietor's insurance coverage, and not to proof of general compensability.[2]

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[1] SAIF argues, for example, that, to the extent medical opinions regarding compensability are based on claimant's uncorroborated statements or descriptions of work activities and causation, those opinions are legally insufficient to prove compensability.

[2] There is no dispute about the sufficiency of claimant's proof of coverage in this case.

The issue before us is one of basic, if by no means simple, statutory construction. It is also a question of first impression; no reported Oregon decision has construed ORS 656.128(3). ORS 656.128 reads:

> "(1) Any person who is a sole proprietor, or a member of a partnership, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter.
>
> "(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. The person shall promptly notify the insurer whenever the status of the person as an employer of **<130 Or App 509/510>** subject workers changes. Any subject worker employed by such a person after the effective date of the election of the person shall, upon being employed, be considered covered automatically by the same guaranty contract that covers such person.
>
> "(3) *No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.*
>
> "(4) Any person subject to this chapter as a worker as provided in this section may cancel such election by giving written notice to the insurer. The cancellation shall become effective at 12 midnight ending the day of filing the notice with the insurer." (Emphasis supplied.)

In construing the emphasized subsection (3), we look first to the statute's text and context. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993). We conclude from that inquiry that the legislature, in enacting ORS 656.128(3), intended the corroborative evidence requirement to apply to proof of compensability, and not merely of insurance coverage.

The statutory text is straight-forward. Although the "corroborative evidence" language does not, by itself, specify what must be corroborated, the natural textual antecedent for that requirement is the phrase "no claim shall be allowed or paid under this section." Thus, the corroboration requirement pertains to facts essential to the allowance or payment of claims for compensation, *i.e.*, compensability. Sole proprietors or partners making claims for compensation by virtue of ORS 656.128 must present corroborative evidence of compensability.

The Board's contrary, and much narrower, reading of the statute focused on the use of the term "section" in ORS 656.128(3). Claimant argued, and the Board agreed, that because ORS 656.128 pertains generally to election of workers' compensation coverage by sole proprietors and partners, the reference to "this section" in ORS 656.128(3) limited the corroborative evidence requirement to the principal subject of ORS 656.128, *i.e.*, coverage. The Board noted, particularly, that if the legislature had intended to require corroboration of compensability in general, it would have **<130 Or App 510/511>** employed the term "this chapter" (*i.e.*, ORS chapter 656), rather than "this section."[3]

We reject the Board's reading for several reasons. First, that reading, which depends exclusively on "section," ignores the rest of the text. As noted, given the statute's syntax, the corroboration requirement must pertain to facts essential for allowance or payment of a "*claim.*" Coverage is not a "claim" that can "allowed" or "paid." It is, rather, just one of a universe of facts that a claimant may have to prove in establishing an entitlement to compensation.

Second, in a related sense, the Board's interpretation impermissibly "insert[s] what has been omitted" from the statute. ORS 174.010. The plain language of ORS 656.128(3) speaks, without qualification, of "corroborative evidence." It does not say "upon corroborative evidence *of coverage.*"

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[3] In so holding, the Board noted that ORS 656.128(1), (2) and (4), refer to "this chapter."

Third, the Board's preoccupation with the use of "section" is misplaced. If "chapter" were substituted for "section" in ORS 656.128(3)--e.g., "No claim shall be allowed or paid *under this chapter* * * *"--the statute would suggest, erroneously, that the corroborative evidence requirement applied to *all* claims under ORS chapter 656.

Finally, limiting the corroborative evidence requirement to proof of insurance coverage makes little sense. As a practical matter, insurance coverage is easily and conclusively documented. Indeed, under the Board's reading, the corroboration requirement would apply only in those extremely rare cases in which sole proprietors or partners claimed to have compensation coverage but were unable to produce proof of insurance. Conversely, legislative concern that sole proprietors or partners might seek compensation for nonwork-related conditions seems much more plausible.[4] See ORS 656.140(5) (imposing corroborative evidence requirement on persons, including partners, who own or have leasehold interest in certain heavy equipment, which they operate for hire, and who elect workers' compensation coverage). <130 **Or App 511/512**> *Accord* ORS 742.504(2)(g)(B) (requiring corroborating evidence of "phantom vehicle" accidents).

We are aware that our interpretation of ORS 656.128(3) means that some claimants who would otherwise be entitled to recover compensation may be unable to do so for lack of corroborative evidence of compensability. Yet that was the legislature's choice. The statute's text and context permit no other conclusion.

Reversed and remanded for reconsideration.

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[4] There appears to be no recorded legislative history of ORS 656.128(3), which was enacted in substantially its present form in 1941. Or Laws 1941, ch 206, 1.

Cite as 130 Or App 525 (1994) October 12, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE OF OREGON, **DEPARTMENT OF HUMAN RESOURCES**, Respondent,
and LORI D. KUSCHNICK, Obligee - Respondent,
v.
RANDY L. **LOVELL**, Appellant.
(146825; CA A81354)

Appeal from Circuit Court, Marion County.
Duane R. Ertsgaard, Judge.
Argued and submitted July 5, 1994.
Darrell E. Bewley argued the cause for appellant. With him on the brief was Estell and Bewley.
Rolf C. Moan, Assistant Attorney General, argued the cause for respondent Department of Human Resources. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
No appearance by obligee - respondent Lori D. Kuschnick.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Appeal dismissed.

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130 Or App 527> Father appeals from an order denying his motion to vacate an *ex parte* order obtained by the Department of Human Resources (DHR) to withhold workers' compensation benefits. We dismiss the appeal.

Father was injured at work and entered into a settlement of that claim with the insurer. The terms of the agreement provided that father would release his right to temporary and permanent disability, vocational rehabilitation and survivor's benefits in exchange for a lump sum payment. DHR filed a motion *ex parte*, seeking an order directing the insurer to withhold 25 percent of the settlement, because father owed past-due child support payments. The trial court granted the motion and father did not appeal. More than seven months later, father moved to vacate the *ex parte* order, contending that "the order rendered is not supported by statute or finding of fact, and therefore is invalid and voidable and should be set aside." The trial court denied the motion.

The threshold issue is whether we have jurisdiction. ORS 19.010(2) provides, in part:

> "For the purpose of being reviewed on appeal the following shall be deemed a judgment or decree:
>
> "* * * * *
>
> "(c) A final order affecting a substantial right, and made in a proceeding after judgment or decree."

Although the trial court's order denying father's motion fits within the literal terms of that statute, it is well established that an order denying a motion to vacate an appealable order or judgment is not appealable. *Columbia Auto Works v. Yates*, 176 Or 295, 156 P2d 561 (1945); *Fehrenbacher v. Fehrenbacher*, 76 Or App 244, 246, 708 P2d 1197 (1985).[1] Father could have raised the issues raised in his motion on direct appeal, but he did not.

Appeal dismissed.

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[1] There are two exceptions to the general rule. Neither applies in this case.

Cite as 130 Or App 564 (1994) October 12, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of a Medical Fee Dispute Darrell D. Hendrix, Claimant, Sedgwick James of Oregon, Insurer.

SEDGWICK JAMES OF OREGON, Petitioner,
v.
DARRELL D. **HENDRIX** and DEPARTMENT OF INSURANCE AND FINANCE, Respondents.
(H93-010; CA A80854)

Judicial Review from Department of Insurance and Finance.
Argued and submitted September 6, 1994.
Jaurene R. Judy argued the cause for petitioner. With her on the brief was Terrall & Associates.
Anita C. Smith argued the cause for respondent Darrell D. Hendrix. With her on the brief were Darrell E. Bewley and Estell and Bewley.
J. Dean Taylor, Assistant Attorney General, argued the cause for respondent Department of Insurance and Finance. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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130 Or App 566> Employer petitions for review of an order of the Department of Insurance and Finance (DIF)[1] in this medical fee dispute. We affirm.

Claimant sustained a compensable injury to his back. Employer accepted the claim, then closed it by a notice of closure, which awarded temporary total disability, but no permanent partial disability. Employer denied permanent disability benefits on the basis of the report of Dr. Woolpert, who concluded that "I do not think there is any basis for permanent impairment." Claimant requested reconsideration of the denial of permanent disability benefits and requested the appointment of a medical arbiter, pursuant to ORS 656.268(7), which provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director."

Employer objected to the appointment of a medical arbiter, arguing that there had been no disagreement with the impairment used in rating claimant's disability, because Woolpert had concluded that there was no permanent impairment.

DIF appointed a medical arbiter and ordered employer to pay for the arbiter's examination. Employer refused. DIF then initiated this fee dispute proceeding. Following a hearing, DIF concluded that it correctly appointed a medical arbiter and that employer is required to pay for the arbiter's examination.

On review, employer asserts two assignments of error. First, it contends that DIF erred in assuming jurisdiction to consider the matter of employer's failure to pay for the arbiter's examination. According to employer, the gist of its dispute is not the amount of fees for the arbiter's examination, but instead the authority of DIF to order the examination in the first place. DIF and claimant argue that the case **<130 Or App 566/567>** falls squarely within the agency's jurisdiction to hear disputes regarding fees for medical services. We agree with DIF and claimant.

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[1] The department has since been renamed the Department of Consumer and Business Services. ORS 705.105.

ORS 656.248(13) provides, in part:

> "When a dispute exists between an insurer or self-insured employer and a medical service provider regarding the amount of a fee for medical services, notwithstanding any other provision of this chapter, the director may resolve the dispute in such summary manner as the director may prescribe."

This proceeding was initiated upon employer's refusal to pay the amount DIF demanded for medical services. The fact that employer contends that it does not owe any amount does not mean that its dispute is not about the "amount of a fee for medical services," as described in ORS 656.248(13).

Second, employer asserts that DIF erred in concluding that the appointment of a medical arbiter was required in this case. Employer contends that an impairment rating of zero is insufficient to trigger DIF's obligation to appoint a medical arbiter. According to employer, there must be a determination of some impairment, with which claimant disagrees on the basis of contrary medical evidence, before DIF is required to appoint a medical arbiter. DIF and claimant argue that, under the statute, all that is required is a "disagreement with the impairment used" in rating claimant's disability. In this case, they argue, because there plainly is a disagreement concerning claimant's impairment, DIF did not err.[2]

When we construe a statute, we attempt to ascertain the intention of the legislature, looking first to the text and the context of that statute. Only if the text and the context of the statute leave the legislature's intent unclear may we <**130 Or App 567/568**> resort to legislative history. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993).

In this case, the text of the statute is quite plain. It requires the appointment of a medical arbiter when there is a "disagreement with the impairment" used to rate claimant's disability. The fact that claimant's disability was rated at zero does not alter the fact that some determination of his impairment was made, with which claimant disagrees. Nothing in the text or the context of the statute supports employer's contention that the obligation to appoint a medical arbiter is triggered only by a disagreement with a finding that claimant was impaired to some extent greater than zero, and that claimant's disagreement with that impairment evaluation must be supported by contrary medical evidence. To the extent that there is any ambiguity left unresolved by the text and the context, our review of the legislative history reveals no contrary legislative intent.

Affirmed.

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[2] DIF and claimant also cite in support of their argument DIF's implementing regulations, which provide in part:

> "When a basis for the request for reconsideration is a disagreement with impairment findings used in rating the worker's disability, the director shall appoint an arbiter or a panel of medical arbiters * * *." OAR 436-10-048(1).

At oral argument, employer argued, for the first time, that the rule itself is invalid. That argument has not been preserved. Employer did not bring this proceeding as a rule challenge under ORS 183.400, and did not assert the invalidity of DIF's rule at any stage in proceedings below.

Cite as 130 Or App 594 (1994) October 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ASSOCIATION OF OREGON LOGGERS, INC., an Oregon corporation; D.R. JOHNSON LUMBER CO., an Oregon corporation, MALHEUR TIMBER OPERATORS, INC., an Oregon corporation, XL TIMBER, INC., an Oregon corporation and ZIMBRICK LOGGING, INC., an Oregon corporation, Petitioners,

v.

DEPARTMENT OF INSURANCE AND FINANCE, Gary Weeks, Director, and OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, (OR-OSHA), Respondents.

(CA A78305)

Judicial Review of Administrative Rules.

Argued and submitted December 6, 1993.

George W. Goodman argued the cause for petitioners. With him on the brief were Jerry K. Brown and Cummins, Brown, Goodman, Fish & Peterson, P.C.

John T. Bagg, 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.

Adam T. Stamper and Cowling & Heysell filed a brief *amicus curiae* for the Chamber of Medford/Jackson County.

Before Deits, Presiding Judge, and Riggs and Haselton,* Judges.

DEITS, P.J.

Rules held valid.

*Haselton, J., *vice* Durham, J.

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130 Or App 596> In this proceeding under ORS 183.400, petitioners challenge the validity of certain rules of the respondent Oregon Occupational Safety and Health Division (OR-OSHA) of the Department of Insurance and Finance.[1] The rules were promulgated in 1992 to implement OR-OSHA's authority under ORS chapter 654 to regulate health and safety in places of employment.

In their first two assignments, petitioners contend that the statement of need for the rules and the statement of fiscal impact were inadequate to satisfy ORS 183.335(2)(b)(B) and (D), respectively. Their first assignment of error is that the agency's statement of need is "categorically false," because it incorrectly describes the agency's legal obligation to adopt a penalty scheme. Their principal objection is to the statement in the notice that "Oregon OSHA is required by its contract with federal OSHA to adopt identical revisions to its penalties." Petitioners argue that, in its view, OR-OSHA is not obligated to adopt an identical penalty scheme and that, because of the agency's misstatement of its legal obligation, the statement of need fails to give proper notice of rulemaking.

However, even assuming that petitioners' understanding of the law is correct, that does not render the statement of need and notice of rulemaking invalid. The purpose of the notice of rulemaking is to alert interested persons that the agency's proposed action may have some effect on them. The notice here fulfilled that function. Indeed, the opportunity for petitioners, and others, to question the agency's legal premises at the time of the hearing is one of the matters that the advance notice is designed to assure under the statute. *See* ORS 183.335(2)(a).

Petitioners argue in their second assignment of error that the agency's fiscal impact statement was inadequate. We disagree. The notice acknowledged that it was uncertain what the impact on specific businesses due to the change in penalties might be, but stated that "historical trends and averages have been used to estimate that the penalties for the average **<130 Or App 596/597>** Oregon employer will rise by 65 percent to 75 percent or $400 to $500 per citation." As we held in *Troutledge, Inc. v. Dept. of Fish & Wildlife*, 113 Or App 123, 830 P2d 622, *rev den* 314 Or 392 (1992), agencies are not required to speculate as to potential fiscal impacts of their actions. They are only required to use available information in formulating the statement of fiscal impact. Based on the information available to the agency here and the uncertainty of the impacts, we hold that the agency's statement of fiscal impact was adequate. *See also Don't Waste Oregon Committee v. EFSC*, 320 Or 132, ___ P2d ___ (1994).

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[1] Respondents include OR-OSHA, the department and its director. We will refer to them collectively as "respondents."

In their third assignment, petitioners contend that various specific rules either exceed the agency's statutory authority or are unconstitutional. Four statutory provisions play a prominent role in petitioners' arguments under this assignment.[2] ORS 654.025(2) provides, in relevant part:

> "The director and the board may make, establish, promulgate and enforce all necessary and reasonable regulations, rules, standards, orders and other provisions for the purpose of carrying out their respective functions under ORS 654.001 to 645.295 and 654.780, notwithstanding any other statutory provisions which may be to the contrary."

ORS 654.025(3)(c) provides:

> "In the event a state of facts or condition constitutes a violation of more than one rule, regulation, standard or order of the director or any other agency pertaining to occupational safety or health, the state of facts or condition shall be the basis for the issuance of only one citation and proceeding or the assessment of only one penalty unless the statute specifically provides that a continuation of a state of facts or a condition constitutes a new violation."

ORS 654.025(5) provides, in part:

> "The director and the Board may do and perform all things, whether specifically designated in ORS 654.001 to 654.295 and 654.750 to 654.780 or in addition thereto, which are necessary or convenient in the exercise of any power, authority or jurisdiction conferred upon them by ORS 654.001 to 654.295 and 654.750 to 654.780."

130 Or App 598> ORS 654.086 provides, as material:

> "(1) The director or the authorized representative of the director is hereby granted the authority to assess civil penalties as provided by this section for violation of the requirements of any state occupational safety or health statute or the lawful rules, standards or orders adopted thereunder as follows:
>
> "(a) Any employer who receives a citation for a serious violation of such requirements shall be assessed a civil penalty of not less than $50 and not more than $7,000 for each such violation.
>
> "(b) Any employer who receives a citation for a violation of such requirements, and such violation is specifically determined not to be of a serious nature, may be assessed a civil penalty of not more than $7,000 for each such violation.
>
> "(c) Any employer who willfully or repeatedly violates such requirements may be assessed a civil penalty of not more than $70,000 for each violation, but not less than $5,000 for a willful violation.
>
> "(d) Any employer who receives a citation, as provided in ORS 654.071(4), for failure to correct a violation may be assessed a civil penalty of not more than $7,000 for each day during which such failure or violation continues.
>
> "(e) Any employer who knowingly makes any false statement, representation or certification regarding the correction of a violation shall be assessed a civil penalty of not less than $100 and not more than $2,500.
>
> "(f) Any employer who violates any of the posting requirements, as prescribed under the provisions of ORS 654.001 to 654.295 and 654.750 to 654.780, shall be assessed a civil penalty of not more than $1,000 for each violation.

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[2] All statutory references and quotations in the remainder of this opinion are to the versions of the statutes in effect at the time that the challenged rules were adopted.

"(g) Any person who violates the provisions of ORS 654.082(2) or (3) shall be assessed a civil penalty of not less than $100 and not more than $5,000 for each such violation.

"(h) Notwithstanding paragraph (b) of this subsection, an employer who substantially fails to comply with ORS 654.174(1) shall be assessed a civil penalty of not less than $250 and not more than $2,500 for each such violation.

"(i) Any insurer or self-insured employer who violates any provision of ORS 656.451, or any rule or order carrying out ORS 656.451, shall be assessed a civil penalty of not more than $2,000 for each violation or $10,000 in the aggregate for **<130 Or App 598/599>** all violations within any three-month period. Each violation, or each day a violation continues, shall be considered a separate offense.

"(2) For the purposes of ORS 654.001 to 654.295 and 654.750 to 654.780 a serious violation exists in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations or processes which have been adopted or are in use, in such place of employment unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation."

Petitioners first challenge the validity of OAR 437-01-015(53)(b)(E), which defines an "egregious" violation:

"Those conditions which normally constitute a flagrant violation of the OSEAct or OR-OSHA standards or regulations such that each instance of the violation is cited separately."

They also challenge OAR 437-01-175:

"For a willful violation, the Administrator, after considering the facts of the violation, may assess a penalty of not less than $5,000, nor more than $70,000. *For egregious violations, the Administrator may assess a separate penalty for each instance of a violation.*" (Emphasis supplied.)

Petitioners make a threefold attack on the two rules: First, they contend, ORS 654.086 establishes the types of violations for which civil penalties may be assessed, *e.g.*, "serious," "repeatedly," "willful," and respondents' attempt to create by rule an "egregious" category that does not appear in the statute exceeds the agency's statutory authority. Second, according to petitioners, the language we have emphasized in our quotation of OAR 437-01-175 violates ORS 654.025(3)(c), by purporting to confer authority on OR-OSHA to penalize separately what petitioners describe as "every incident of exposure to a hazard." Finally, petitioners maintain that the rules are unconstitutionally vague.

Respondents argue in response to the first prong of petitioners' challenge that ORS 654.025(2) and (5) confer exceedingly broad regulatory authority on them. They assert **<130 Or App 599/600>** that subsection (5) "gives the director authority to supplement any statutory provision as may be needed to fulfill the purposes of the Act." Hence, if the "egregious violation" category established by the rules amounts to an amendment of ORS 654.086, as petitioners essentially maintain, respondents appear to regard that as permissible under ORS 654.025. Respondents contend alternatively that, in any event, the creation of the egregious violation category is within the authority delegated to the agency by the statutes.

The authority granted to the agency is quite broad. However, we do not believe that the agency is entitled to "supplement" the statute in the sense of effectively altering or acting inconsistently with it. We conclude, however, that the inclusion of "egregious violations" in the rule is not at variance with the types of violations delineated in ORS 654.086. OAR 471-01-015(53) defines "violations" of various types. Subsection (a) of that rule sets forth definitions of "[s]pecific classifications of violations," which include "serious," "other than serious" and "minimal." Subsection (b) then defines "[s]pecific types of the above classifications," and includes "egregious" violations among them, along with such other types as

"willful," "unabated," "repeat" and "first-instance." Given that context, it seems apparent that the agency treated "egregious violations" as a subcategory of, rather than a different kind of violation than, "serious violations," and that it construed the statutory term "serious" accordingly. Stated differently, under the rules, "egregious" is not a different type of violation from the ones expressly defined in the statute; it is an interpretive explication of one of the types that is specifically covered by the statute. We conclude that that interpretation is well within the scope of the extremely broad delegated authority that ORS 654.025 confers on respondents. *See Accident Prev. Div. v. Hoffman Const.*, 64 Or App 73, 667 P2d 543 (1983).

Moreover, the only distinct consequence that the rules attach to an egregious violation, as far as we are apprised, is that a "separate penalty for each instance of a violation" is authorized. That differs from the consequence that attaches to a "serious violation" under ORS 654.086(1)(a) only in that the statute says that a penalty *shall* be assessed "for each such violation," while the rule uses the **<130 Or App 600/601>** word "may."[3] We find no inconsistency of the kinds petitioners contend exist between the challenged rules and ORS 654.086.

For a similar reason, the second basis for petitioners' challenge to the egregious violation rules also fails. Petitioners understand OAR 437-01-175 to be at variance with the requirement of ORS 654.025(3)(c) that, when the same state of facts or condition violates more than one rule, only one penalty may result. However, the rule does not have the vice that petitioners ascribe to it. It does not punish the same act twice; rather, it makes separate incidents of the same kind of misconduct separately punishable. That is consistent with the statute.

Finally, assuming that vagueness *could* be a basis for invalidating a rule that relates to civil rather than penal sanctions, *but see Davidson v. Oregon Government Ethics Comm.*, 300 Or 415, 712 P2d 87 (1985), a vagueness issue like the one here, that does not involve constitutional speech protections, cannot be raised or adjudicated through a facial challenge. *See State v. Albee*, 118 Or App 212, 847 P2d 858, *rev den* 316 Or 528 (1993). This ORS 183.400 proceeding does and can present only facial challenges to the rules in question. *See Don't Waste Oregon Committee v. EFSC, supra.* Petitioners do not demonstrate that either OAR 437-01-015(53)(b)(E) or OAR 437-01-175 is invalid.

A number of petitioners' specific challenges are predicated on their view that certain of the rules are not "necessary and reasonable" within the meaning of ORS 654.025(2). They base their challenges to OAR 437-01-052 (relating to the timing of notification of major injurious episodes), OAR 437-01-053 (proscribing the disturbance of scenes of a catastrophe or fatality), and several other rules on this theory. However, when all is said and done, petitioners offer no more than their own subjective estimations in raising and answering questions concerning the reasonableness and necessity of the rules. Those are questions that the delegative statutes **<130 Or App 601/602>** plainly give the agency wide latitude to answer. Far more than petitioners advance here is necessary to show that the agency's answers fall outside the permissible range of the legislative delegation.

Petitioners understand two of the rules, OAR 437-01-057 and OAR 437-01-075, as allowing inspections to take place without compliance with ORS 654.067 and/or constitutional search protections. In our view, these arguments are premised on an incorrect reading of the language of the rule.

Petitioners' remaining contentions are either answered by our earlier discussion of related arguments, or else require no discussion.[4]

Rules held valid.

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[3] No party argues that the rule is invalid for that reason.

We note that this is a facial challenge, and nothing in this opinion is intended as a comment on possible "as applied" proceedings that might be brought in response to actual penalty assessments.

[4] We have reviewed and considered petitioners' arguments, as well as those of the *amicus*, and find no basis in eithers' arguments for invalidating the rules.

Cite as 130 Or App 615 (1994) October 19, 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.

On respondent SAIF Corporation's motion for reconsideration filed April 13, 1994. Opinion filed March 30, 1994. 127 Or App 153, 872 P2d 423.

Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, for motion.

Before Deits, Presiding Judge, and Richardson, Chief Judge,* and Riggs, Judge.

DEITS, P.J.

Reconsideration allowed; opinion adhered to.

*Richardson, C.J., *vice* Durham, J.

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130 Or App 617> Respondent SAIF moves this court to reconsider a portion of our decision in this case. 127 Or App 153, 872 P2d 423 (1994). Specifically, SAIF requests that we modify the part of the opinion that concludes that unless an employee performed duties described by two or more classifications previously assigned to the employer, the employee did not perform an "interchange of labor" and, thus, DIF's[1] rules regarding the allocation of payroll among classifications do not apply. OAR 836-42-055(4); OAR 836-42-060(1). We allow reconsideration and adhere to our opinion.

SAIF asserts that we erred by usurping DIF's responsibility to interpret its own rules. The disputed rules are OAR 836-42-060(1) and OAR 836-42-055(4). 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.)

In our opinion, we read the pertinent language of those rules to mean that a classification must have been assigned to an employer before the employee performs the duties in order for there to be an interchange of labor. Our reading was based on the plain language of the rules, which provides that an "interchange of labor" occurs when an employee performs duties described by two or more classifications assigned to an employer. The use of the term "assigned" **<130 Or App 617/618>** indicated to us that the classifications must have been made before the time that the duties were performed.

SAIF now argues that DIF would interpret the term differently than we did; that DIF's rules do not specify when a classification must be assigned in order for there to be an "interchange of labor" allowing a division of payroll between classifications and that even if a classification is assigned to an employer after the duties have been performed, the employee's entire payroll may be allocated to the new classification, if no verifiable records exist.

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[1] DIF is now known as the Department of Consumer and Business Services.

There are a number of problems with SAIF's argument. First, this is not the argument that SAIF made on judicial review. Petitioner argued on review that because SAIF had assigned to it only one classification, its employee could not have performed an interchange of labor. Accordingly, petitioner contended that SAIF could not allocate the employee's entire payroll to the new classification on finding that petitioner failed to maintain verifiable payroll records documenting the time that the employee spent performing duties described by the then-unknown classification. SAIF responded:

> "The short answer to this contention is that, even assuming that the administrative rule does not apply, the other rule cited by DIF does apply and mandates the same result."

SAIF then cited NCCI Basic Manual Rule IV-E-2, Oregon Special Pages, which says that an employer can allocate payroll "to any such classifications *which may be properly assigned to the employer.*" (Emphasis SAIF's.) SAIF concluded:

> "Under the Basic Manual rule, the fact that the classification to which payroll is ultimately allocated was not a classification originally assigned to the employer is immaterial."

In our earlier opinion, we held that, even if we were to interpret the Basic Manual rule as suggested by SAIF, the plain language of the administrative rules would prevail over an inconsistent, non-APA rule. We adhere to that conclusion.

The other problem with SAIF's argument on reconsideration is that, even if it had been presented to us earlier, it is not clear from DIF's order whether DIF applied the administrative rules, let alone whether it clearly interpreted the **<130 Or App 618/619>** rules in the manner that SAIF now contends is appropriate. The argument of a party is not the equivalent of an interpretation by an agency. *See West v. Clackamas County*, 116 Or App 89, 840 P2d 1354 (1992). Although DIF cited OAR 836-42-060(1), its analysis and conclusion appear to be based solely on the NCCI rule. After quoting the relevant NCCI rule, DIF said:

> "Employers whose employees perform two or more job duties *described by a separate SCOPES code classification* may allocate their hours in each classification if the employer maintains verifiable payroll records." (Emphasis supplied.)

That comment suggests that DIF was interpreting the NCCI rule as SAIF had asserted: Payroll may be divided when an employee performs duties described by two or more classifications that *are or could* be assigned to an employer. However, such an interpretation is inconsistent with the plain language of DIF's adopted administrative rules and is inconsistent with SAIF's current argument.

Further, in the course of its analysis, DIF addressed whether petitioner maintained verifiable records and explained:

> "The purpose behind the requirement that a payroll record be verifiable is to enable a third party, such as an insurer, to determine *if an employer is correctly reporting a divided payroll by classification.*" (Emphasis supplied.)

That comment suggests that DIF interprets NCCI's rule and/or its own rules to apply to situations where an employer is reporting a divided payroll among known classifications. Such a reading is consistent with the plain language of the administrative rule and is at odds with SAIF's current argument.

In any event, even if SAIF had made this argument before us on review and DIF had clearly interpreted the administrative rules in the manner that SAIF now asserts, as we concluded in our earlier opinion, such an interpretation would be inconsistent with the wording of the rules, considered in their context. *See Don't Waste Oregon Committee v. Energy Facility Siting Council*, 320 Or 132, ___ P2d ___ (1994).

Reconsideration allowed; opinion adhered to.

Cite as 130 Or App 620 (1994) October 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Brian W. Andrews, Claimant.

SAIF CORPORATION and CARCO INDUSTRIES, INC., Petitioners,
v.
BRIAN W. **ANDREWS**, Respondent.
(WCB 91-18171; CA A81311)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 21, 1994.
Steve Cotton, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Robert Wollheim argued the cause for respondent. With him on the brief was Welch, Bruun, Green & Wollheim.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Affirmed.

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130 Or App 622> SAIF Corporation seeks review of an order issued by the Workers' Compensation Board. SAIF argues that the Board misinterpreted ORS 656.262(6) and, as a result, improperly assigned the burden of proof. We affirm.

On August 24, 1991, claimant injured his left ankle while playing softball at a company picnic. SAIF accepted his claim on November 19, 1991, but rescinded the acceptance and denied the claim on the following day. Claimant requested a hearing and the referee determined that his claim was not compensable. On appeal, the Board reversed the referee's order, concluding that SAIF had failed to prove by clear and convincing evidence that claimant's injury was not compensable. SAIF requested reconsideration and argued that the burden of proof was improperly assigned.[1] The Board determined that the allocation of the burden of proof at the hearing was proper under ORS 656.262(6).[2]

SAIF assigns as error the Board's interpretation of ORS 656.262(6). We review for errors of law. ORS 183.482(8)(a). ORS 656.262(6) provides, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer or insurer 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 **<130 Or App 622/623>** the paying agent is not responsible for the claim." (Emphasis supplied.)

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[1] Claimant urges us to affirm the Board's decision on the basis that SAIF failed to preserve the burden of proof issue at the administrative hearing. In its order on reconsideration, the Board determined that SAIF had not preserved the burden of proof issue but, nevertheless, proceeded to address the merits of that issue adversely to SAIF. Because the Board addressed the substance of SAIF's argument, the burden of proof issue was preserved for our review.

[2] After the Board issued its first order on reconsideration, SAIF requested a second reconsideration. The Board undertook review, and adhered to the decision in the first order on reconsideration with minor supplementation.

Under the Board's interpretation of the statute, once an insurer accepts a claim, it has two years from that date to issue a "back-up" denial. If that denial is contested, the insurer must demonstrate by clear and convincing evidence that the claimant's injury is not compensable. SAIF argues that the two-year back-up denial period, with its concomitant shift in the burden of proof, is not triggered by claim acceptance. Rather, SAIF contends, the two-year period does not begin to run until the 90-day period in which it must accept or deny the claim expires.

In interpreting a statute, we must discern legislative intent, and our starting point is to examine the text of the statute itself. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). Here, the statute unambiguously states that the two-year back-up denial period runs *from the date of claim acceptance*. To accept SAIF's interpretation of ORS 656.262(6) would require us to omit what the legislature has inserted and ignore the statute's clear direction, which we may not do. ORS 174.010. The Board correctly determined that the two-year back-up denial period began once SAIF accepted the claim. Therefore, when SAIF issued a subsequent denial and claimant challenged that denial, SAIF was required to prove by clear and convincing evidence that claimant's injury was not compensable. The burden of proof was properly allocated under ORS 656.262(6).

Affirmed.

Cite as 131 Or App 164 (1994) November 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of George L. Gates, Claimant.

GEORGE L. **GATES**, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION, MT. ANGEL ABBEY, PIONEER MARKET and UNITED EMPLOYERS INSURANCE, Respondents.
(WCB Nos. 92-07879, 92-01524; CA A80785)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 14, 1994.
Robert G. Dolton argued the cause and filed the brief for petitioner.
James D. McVittie argued the cause and filed the brief for respondents Liberty Northwest Insurance Corporation and Mt. Angel Abbey.
No appearance for respondents Pioneer Market and United Employers Insurance.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
DEITS, P.J.
Reversed and remanded for reconsideration.

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131 Or App 166> Claimant seeks review of the Board's order denying his request for an insurer-paid attorney fee under ORS 656.386(1). He argues that because his attorney was instrumental in obtaining compensation for him, he is entitled to an insurer-paid attorney fee. We reverse and remand.

Claimant injured his low back while working for Mt. Angel Abbey and Seminary in October, 1987. He was awarded 31 per cent unscheduled permanent partial disability as a result of the injury. In September, 1991, while working for Pioneer Market, he again injured his back. He filed claims with both employers. Both Mt. Angel Abbey and Pioneer Market denied responsibility and compensability. A hearing was held on the denials on September 9, 1992. At the beginning of the hearing, both employers withdrew their compensability denials. The hearing then continued to determine responsibility. The referee held that the condition was compensable, but concluded that claimant did not sustain a new injury. Accordingly, Mt. Angel Abbey's denial was set aside.

The referee, however, did not award claimant attorney fees because he concluded that the sole issue in the case was responsibility. Claimant filed a motion for reconsideration requesting an award of attorney fees. The referee again denied attorney fees based on his conclusion that compensability was not an issue at hearing and that, therefore, under the language of ORS 656.386(1) and our decision in *Multnomah County School Dist. v. Tigner*, 113 Or App 405, 833 P2d 1294 (1992), fees could not be awarded. Claimant sought Board review of the denial of attorney fees, and the Board affirmed.

Claimant assigns error to the Board's conclusion that it lacked authority to award attorney fees under ORS 656.386(1) under these circumstances. ORS 656.386(1) provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, **<131 Or App 166/167>** then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Mt. Angel Abbey first argues that this court lacks "jurisdiction" to consider the issue of attorney fees, because claimant failed to raise the issue before the referee. However, even if employer were correct that the issue was not raised, this is an issue of preservation and would not deprive this court of jurisdiction. In any event, claimant raised the issue on reconsideration before the referee and, on *de novo* review, the Board chose to address the issue. Because our review is of the Board's order that decided the issue, the question is properly before this court.

We begin our analysis with the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). The question here is whether attorney fees are authorized in these circumstances by the language of ORS 656.386(1). After considering the text and context, however, we are unable to discern the intent of the legislature as to how the statute applies in these circumstances. One provision of the statute that might be applicable here reads: "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." If this provision is read to refer to a hearing on *compensability* not being held, then attorney fees would be authorized by this provision. However, whether the legislature intended that meaning is not clear from the language used.

Another provision of ORS 656.386(1) that might authorize attorney fees here, even if we do not conclude that a "hearing" means a hearing on compensability, provides that when compensation is denied and "the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee." If the terms "prevails finally at the hearing" include a situation where the issue of compensability is not resolved by the referee, but the claimant otherwise prevails at hearing, then attorney fees would be authorized in these **<131 Or App 167/168>** circumstances. Again, the text and context do not clearly indicate the legislature's intent on this question.

Because the legislative intent is not clear from the text and context of the statute, we need to consider the legislative history of the statute. *PGE v. Bureau of Labor and Industries, supra.* In *Safeway Stores, Inc. v. Hayes*, 119 Or App 319, 850 P2d 405 (1993), in deciding a question somewhat similar to the one presented here, we reviewed the legislative history of the pertinent language of this statute. In that case, compensation was denied, and a hearing on the issue was held. After the hearing, but before the issuance of a decision by the referee, the parties entered into a stipulation by which the insurer rescinded its denial and accepted the claim. The Board refused to award attorney fees under ORS 656.386(1), because it concluded that the claimant had not prevailed at hearing against the insurer. Initially, we affirmed the Board's decision based on our holding in *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *mod* 108 Or App 230, 814 P2d 558 (1991), in which we held that attorney fees are not authorized by ORS 656.386(1) if the matter of compensability is not resolved by the forum. *Hayes v. Coos Curry Manpower*, 107 Or App 565, 813 P2d 1065 (1991) (*Hayes I*). However, after the legislature amended the statute to authorize attorney fees when "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held," we reconsidered our decision in Jones and allowed an award of attorney fees. In view of that legislative change, we also reconsidered our decision in *Hayes I, supra*, and remanded that case for the Board's reconsideration. *Hayes v. Coos Curry Manpower*, 108 Or App 642, 815 P2d 720 (1991) (*Hayes II*). On remand, the Board concluded, however, that because a hearing was held, the circumstances there did not technically come within the amended language of the statute. The Board concluded, nonetheless, that because the employer placed the compensability of the claim at issue, making it necessary for the claimant to participate in the hearing, an attorney fee should be assessed.

On review of the Board's decision on reconsideration, in *Safeway Stores, Inc. v. Hayes, supra*, we discussed the legislature's intent in amending the statute. We concluded:

> **131 Or App 169>** "The legislature left a gap, however, which, under our interpretation of the statute in our first decision in *Jones*, would exclude this case from the statute's application. The question is whether the statute as amended permits the assessment of attorney fees when a hearing is held but the matter is resolved by stipulation of the parties, rather than by the forum. We conclude that, if, as it has expressly provided, the legislature intended that an attorney fee be available if a hearing is not held, it most certainly intended that an attorney fee be available if a hearing is held and the claimant prevails by reason of a stipulation or withdrawal of the denial before the referee has had the opportunity to issue an order. Accordingly, the fact that the matter was resolved after the hearing but before the issuance of an order does not create an obstacle to claimant's entitlement to assessed attorney fees in this case." *Safeway Stores, Inc. v. Hayes, supra*, 119 Or App at 322.

Similarly, we conclude, based on the legislative history, that the legislature intended to authorize fees in the circumstances in this case. We believe that when the legislature authorized fees in

circumstances where an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, it meant that a hearing on *compensability* is not held. If, as occurred here, an insurer withdraws its denial of compensability before a hearing on that issue begins and the attorney was instrumental in obtaining that withdrawal, attorney fees are authorized under that portion of ORS 656.386(1). *See SAIF v. Allen*, 320 Or 192, ___ P2d ___ (1994).

Employer relies on our decision in *Multnomah County School Dist. v. Tigner, supra.* That case also involved facts somewhat similar to this case. Compensability was denied by one insurer and, therefore, a hearing on the issue was scheduled. However, by the time that the hearing was held, the insurer who had denied compensability had been dismissed from the proceedings. The claimant argued that he was entitled to an award of attorney fees under ORS 656.386(1). We concluded that attorney fees were not authorized for two reasons. First, we held that because none of the insurers who were parties in the proceeding at the time of the hearing had denied the claim, attorney fees were not available under ORS 656.386(1). We explained that fees are authorized by that statute only in cases where compensation has been **<131 Or App 169/170>** denied. That holding alone was dispositive of the attorney fees issue. However, we went on to also hold that fees were not authorized by ORS 656.386(1) because, even if the attorney for claimant was instrumental in obtaining an award of compensation, a hearing was held. Therefore, we reasoned, technically, the circumstances did not come within the language of the statute. That discussion, however, was *dicta.* In view of our conclusion in this case, we now disapprove that language.

For the reasons discussed above, we hold that the Board erred in concluding that it lacked authority to award attorney fees under ORS 656.386(1) and remand to the Board to reconsider the attorney fees award.

Reversed and remanded for reconsideration.

Cite as 131 Or App 282 (1994) November 9, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Martin O. Tadlock, Claimant.

LANE COUNTY, Petitioner,
v.
MARTIN O. **TADLOCK**, Respondent.
(92-10524; CA A82985)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 5, 1994.
Brian L. Pocock argued the cause and filed the brief for petitioner.
Allison Tyler argued the cause for respondent. With her on the brief was Rasmussen & Henry.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Reversed and remanded.

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131 Or App 284> Employer seeks review of an order of the Workers' Compensation Board awarding claimant compensation for head and upper body injuries. We reverse.

Claimant is employed as a deputy sheriff assigned to the Lane County Jail. He is certified as a corrections officer by the Board on Public Safety Standards and Training.[1] After completing his work shift on June 28, 1992, claimant left work in his own car, dressed in civilian clothes. He stopped at a grocery store on the way home on a personal errand. As he walked toward the grocery store, three men approached him shouting profanities. They surrounded him and threatened him. Claimant attempted to reason with the men and then displayed his badge and identified himself as a deputy sheriff. The men assaulted claimant, knocking him unconscious. He suffered injuries to his head and upper body. Employer denied his claim for compensation on the ground that the injury did not arise out of and in the course of his employment.

The Board reversed the referee's denial of compensation. It found that claimant is a certified peace officer, with authority to arrest 24 hours a day, seven days a week, and that he is a commissioned reserve deputy with the same authority. It concluded that claimant's injuries arose out of **<131 Or App 284/285>** and in the course of his employment, because his identity as a deputy sheriff, once revealed, was a "significant cause of the subsequent attack which resulted in the injuries claimed."

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[1] The Board on Police Standards and Training is a state agency charged with establishing minimum standards of physical, emotional, intellectual and moral fitness for police officers, corrections officers and other law enforcement classifications. ORS 181.640(1). Certification is based on the level of training completed and the work assignment. The Board's training manual contains the following definitions:

> "(8) 'Corrections Officer' means an officer or member of a law enforcement unit who is employed full-time thereby and is charged with and primarily performs the duty of custody, control, or supervision of individuals convicted of or arrested for a criminal offense and confined in a place of incarceration or detention other than a place used exclusively for incarceration or detention of juveniles * * *.
>
> "* * * * *
>
> "(11) 'Police Officer' means an officer or member of a law enforcement unit who is employed full-time as a peace officer commissioned by a city, port, school district, mass transit district, county, Indian reservation, the Criminal Justice Division of the Department of Justice, the Oregon State Lottery Commission, or the Governor, and who is responsible for enforcing the criminal laws of this state or laws or ordinances relating to airport security * * *."

On reconsideration, the Board relied on the Lane County Sheriff's Office Policy Manual in concluding that, even if claimant is not a peace officer or a certified reserve deputy, he is subject to "those policies and expectations articulated in the manual which are not limited to employees who do have 24 hour arrest authority."

We review the Board's order for errors of law and for whether its findings are supported by substantial evidence. ORS 183.482(8)(a), (c); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 294, 787 P2d 884 (1990); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Employer first argues that, although claimant is a certified corrections officer, he is not a certified peace officer or reserve deputy whose authority spans 24 hours a day, seven days a week. Employer argues that only certified peace officers and reserve deputies have an affirmative duty or obligation to take some type of action if they observe a crime or if they can prevent a crime from occurring. Because claimant is not a certified peace officer or reserve deputy, employer contends that he was not in the course of his employment when he displayed his badge and that his injury, therefore, is not compensable under the "going and coming rule."

We begin by examining whether substantial evidence in the record supports the finding that claimant is a certified peace officer or a certified reserve deputy.[2] At the hearing, claimant initially testified that he is a certified police officer. On cross examination, however, he admitted that he is a certified corrections officer, but not a certified police officer. He testified that he completed the Oregon Police Academy corrections course and that there is a separate course for police officers. Claimant also testified that he has been trained to make arrests only at the jail and not in the field. In response to his counsel's question whether he believed that he had the right to arrest the individuals who assaulted him, he testified: "I realize at that particular point that I was on **<131 Or App 285/286>** extremely shaky ground, which is why I did everything in my power to diffuse [*sic*] that situation."

By claimant's own admission and testimony, he is not a certified police officer. No evidence in the record supports the Board's contrary finding. Neither do we find any evidence in the record to support the Board's finding that claimant is a reserve deputy.

Next, we examine employer's claim that the Board erred as a matter of law by concluding that, under the Lane County Sheriff's Office Policy Manual, claimant had a duty or obligation to intervene in the incident that resulted in his injuries and compensation claim. The Board relied on the portion of the manual regarding the actions of its employees while they are off duty. The manual provides:

> "Section 5. Off Duty Conduct of Employee
>
> "E - Status of Employees While 'Off Duty' - Employees may be required to take action *in their official capacity at any time without prior notice.* As defined, 'off duty' means the employee's rest periods when they [*sic*] are not assigned specific duties and are free to pursue private interests. It is expected that an employee be physically and mentally prepared to react or to respond to a call to duty. In the event that the employee is not physically or mentally prepared to react or respond per this policy, that employee is to remain personally uninvolved except in the capacity of notifying other capable authorized personnel of the incident and reasons associated with their [*sic*] inability to personally react or respond to the situation.
>
> "*Employees who are certified by the Board on Police Standards and Training as peace officers, and/or commissioned Reserve Deputies who have attained solo status, have police officer authority 24 hours a day, seven days a week.* Any time that a police certified employee of this department and/or a commissioned Reserve Deputy observes a crime being committed that falls within the known jurisdiction of the department, except for traffic offenses, that employee/Reserve Deputy shall be expected to take some initiative to prevent the crime from being committed and/or to assist in the apprehension of the perpetrator with emphasis on the protection of life and property. * * *

---

[2] The terms "peace officer" and "police officer" are used interchangeably.

"* * * * *

"* * * All employees are expected to provide reasonable aid or assistance to all on-duty law enforcement personnel engaged **<131 Or App 286/287>** in law enforcement activities necessitating aid or assistance and/or when requested. *Non-police certified employees may exercise the rights of any citizen, that would be expected of any person, of the community in like circumstances.*" (Emphasis supplied.)

The manual provides that all off duty employees "may be required to take action *in their official* capacity at any time." (Emphasis supplied.) Claimant's official capacity is that of a corrections officer assigned to the county jail. When questioned about what type of action he might be called on to take while off duty, claimant responded: "If you need other extra staffing or an incident has taken place where they need other extra bodies to come in and assist for whatever type of scenario it might be." The manual is clear, as is claimant's understanding, that the obligation imposed on him by the manual while off duty is limited to being called back to the jail to "take action in [his] official capacity" as a corrections officer.

Section 5 of the manual imposes different responsibilities on off duty employees who are certified peace officers or reserve deputies. They have authority 24 hours per day, seven days per week. Those employees have the additional duty or obligation to act if they observe a crime being committed. As discussed above, claimant is neither a certified peace officer nor a certified reserve deputy. Therefore, the section of the manual addressed to those employees does not apply to him.

Claimant's status at the time he was confronted by his assailants was that of an off duty, non-police certified employee who, according to the manual, was no different than any other citizen. The Board erred in concluding that claimant was acting in the course and scope of his employment when he was injured.

Reversed and remanded.

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